Maricopa County
Case Management and Clinical Team Services Plan

Submitted By
Arizona Department of Health Services/Division of Behavioral Health Services
And
Maricopa County
Regional Behavioral Health Authority

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TABLE OF CONTENTS

I. EXECUTIVE SUMMARY

The Arizona Department of Health, Division of Behavioral Health (ADHS/DBHS) and the Maricopa County Regional Behavioral Health Authority (RBHA) developed the following Case Management and Clinical Team Services Plan to serve as a guide for behavioral health service development in Maricopa County. The plan is based on an extensive review of best practice models of case management and service delivery, materials submitted by the Court Monitor's Office, materials gathered from other states using a variety of service delivery models and the Arizona Service Capacity Planning Project (Leff Report). The plan also incorporates many of the activities contained in the Strategic Plans for Dual Diagnosis, Housing and Rehabilitation and Employment.

ADHS/DBHS and the RBHA agreed that instead of implementing specific program enhancements for a limited sector of the population, they had to examine and create a foundation for the entire system. ADHS/DBHS and the RBHA also agreed that change should be sequential. Incremental change is the way systems evolve and systems change requires a long-term commitment from ADHS/DBHS and the RBHA of Maricopa County.

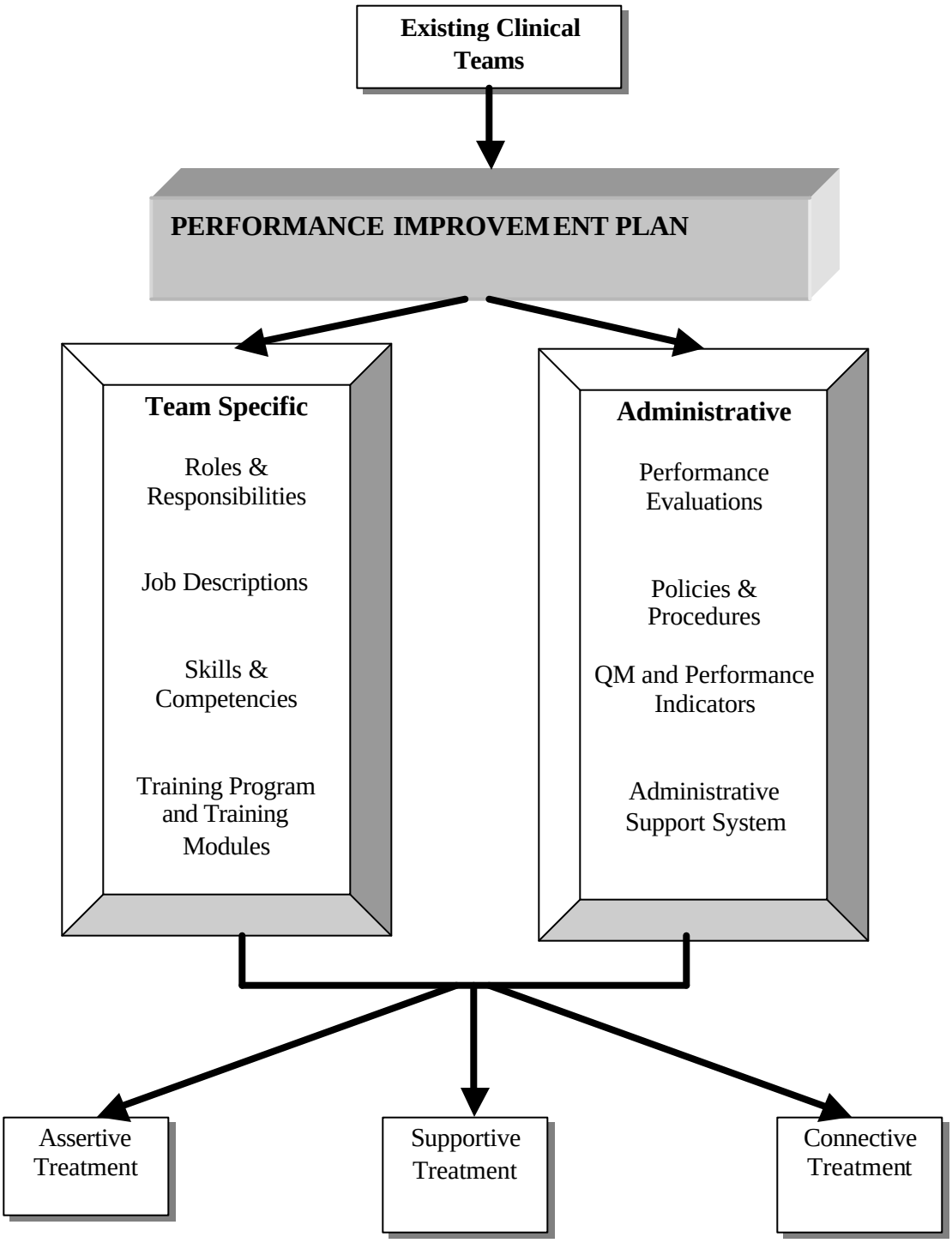
ADHS/DBHS and the RBHA started with the Court Monitor's Plan for Case Management. It quickly became apparent that in order to actualize the principles contained in the Court Monitor's Plan for Case Management, the principles needed to be integrated into a variety of personnel practices, program requirements, agency policies and agency training activities. This Case Management and Clinical Team Services Plan does that and replaces the Court Monitor's Plan for Case Management. Appendix A, *Case Management and Clinical Services Team Cross Reference Chart*, reflects the cross-referencing of the functional criteria in the Court Monitor's Plan for Case Management (see Appendix B, *Functional Criteria for Clinical Team Services).* Both Appendix A and Appendix B are included for reference only, and are not intended for court submission.

The work group examined each principle and determined the areas in which the principle needed to be embedded. Many principles appear in multiple areas. The plan describes the roles and responsibilities of team members, the skills and competencies required for team members, the training programs to ensure that competencies are developed, the performance evaluation process to shape employee performance, Quality Management and outcome indicators and the administrative support system.

This proposal attempts to achieve both a consumer-level of service improvement and administrative level system improvement. The graphic on the following page is a visual display of how the performance improvement plan outlined in this document is multidimensional, covering roles and responsibilities, competencies, training, performance evaluations, policies, performance indicators and administrative infrastructure to support the program.

Throughout the document reference is made to coordination of care and communication with caregivers, family members, and other agencies. All coordination and communication with interested parties is subject to applicable state and federal rules regarding confidentiality of patient information.

Case Management - A Multi-faceted Approach



II. INTRODUCTION

A. PURPOSE – RESPONSE TO THE MONITOR'S CASE MANAGEMENT PLAN

The general purpose of this document is to provide a strategic plan to enhance the current case management system and develop well functioning clinical teams for Maricopa County. This plan:

- Addresses plaintiff's concerns regarding inadequacies within the service delivery system
- Provides the means to improve the overall quality of clinical team services, specifically outlining how these improvements will occur
- Integrates the plans for Rehabilitation and Employment, Housing and Dual Diagnosis Services
- Establishes initial demonstrations of assertive, supportive and connective intensities of treatment (including integration of clinical team specialists in the areas of rehabilitation, housing, co-occurring disorders and independent living), and other activities designed to initiate an orderly transition within the system, without disruption to consumers
- Fosters the development of linkages between clinical, housing, vocational, residential, substance abuse and other services, as well as identifying avenues for enhanced communication between stakeholders.

B. BACKGROUND

This plan to implement fully functioning case management and clinical teams resulted from a collaborative effort involving the Maricopa County RBHA and ADHS/BHS. Input into what defines a well-functioning clinical team was previously sought from consumers, public and private agencies, and staff. An initial step in creating this plan included research regarding best practices and the delivery of clinical case management services, demonstrated throughout this document. Feedback was solicited regarding earlier plan drafts through public forums; revisions have been made based upon input from providers, stakeholders, the Center for Disability Law, the Consumer Advisory Board, and others.

Over the past year, a number of major planning initiatives have taken place regarding the mental health services delivery system. These have included the Maricopa County Strategic Plan for Employment and Rehabilitation, the Maricopa Strategic Plan for Housing, and the Maricopa County Plan for Dual Diagnosis Services, as well as The Arizona Service Capacity Planning Project (or "Leff Report"). These planning efforts were completed as required by the Supplemental Agreement to the Arnold v. Sarn Exit Stipulation. Great care was taken to coordinate the development of this implementation plan with the vocational, housing and dual diagnosis plans to ensure that the overall structure of the clinical teams and delivery of case management services facilitates their stated consumer service objectives. Each of these plans were reviewed individually by the Maricopa County Superior Court and officially accepted by the Court in a formal hearing on August 16, 1999.

Implementation efforts are currently underway for many areas of this plan, especially in regard to existing staff competency determination. Portions of this plan, however, are predicated upon the ability of the RBHA to implement new models of clinical team operation, which may require additional resources to achieve the appropriate mix of specialized team members. This plan is structured in a way that allows for escalation of implementation of additional teams if resources are made available through legislative or other budget actions, both in Maricopa County and Statewide. The unit cost of a team may vary depending on the infrastructure necessary to support roll out of additional teams, but this plan provides the model for rollout and can be adjusted depending on the amount of resources.

C. VISION, MISSION AND PRINCIPLES

The plan for a fully functioning clinical team is based upon an underlying vision and values system for consumer care in Maricopa County that intends to realize a behavioral health system grounded in the recovery model, with an emphasis on consumer self-sufficiency. There is a firm belief that the goal of recovery is the driving force behind the delivery of all services, implying that the consumer may not be "cured", but acquires the skills necessary to fully function, becoming a contributing member of society.

1. Vision

Fully functioning clinical teams emphasize consumer recovery at all levels, augmenting existing supports consumers inherently have and offering an array of levels of care and services necessary to assist consumers in achieving self-sufficiency. This vision results in the design and implementation of innovative programming that integrates holistic treatment alternatives. The consumer is ultimately responsible for the choices they make, relative to the direction of their lives; the clinical team is responsible to offer needed services and assist consumers in accessing them.

2. Mission

The fully functioning clinical team's mission is to support and help an individual to attain an optimum level of functioning, develop healthy interpersonal relationships, experience recovery, become self-determined and a productive member of society by:

- Managing or eliminating the debilitating symptoms of a mental illness
- Promoting the ability to live a productive and satisfying life
- Improving the ability to function in social, educational and vocational roles
- Emphasizing every individual's unique strengths, recovery process, culture and determination.

3. Principles

Operation of the system must be based upon the following principles:

- Clinical teams assist consumers in acquiring the skills necessary to manage or eliminate the debilitating symptoms of a mental illness
- Clinical teams develop partnerships with consumers, promoting the ability to live productive, satisfying and interdependent lives
- Clinical teams foster the development of social role functioning, including educational and vocational roles
- Clinical teams emphasize each consumer's unique strengths, culture and self-determination.

The belief is that to achieve the goal of recovery and progress toward self-sufficiency, consumers require the support and guidance of a well-functioning clinical team. Each clinical team must be individualized, reflecting the consumer's strengths. While the case manager should be a consistent support in a consumer's life, team members may come and go or increase or decrease service intensity based on clinical or environmental issues. One long-term goal is to decrease the number of clinical team members and the type and intensity of services for a consumer as he/she moves toward self-sufficiency, increasing the natural supports in the consumer's life.

D. IMPLEMENTATION PARAMETERS

This plan incorporates the required elements of the draft plan from the Office of the Court Monitor as it relates to the criteria for a well-functioning team. Care has been taken to coordinate the development of this plan with existing and Court-approved plans for vocational, housing and dual diagnosis services. The RBHA for Maricopa County will implement this plan within the following parameters, subject to available resources:

1. Recovery from psychiatric illness and achieving self-sufficiency are the goals of all services provided by the RBHA.

2. Services will be provided to the extent that an adequate array of accessible services (both program and non-program options) exist, with sufficient community integration opportunities.

3. The delivery of care must occur in accordance with professional standards and all Federal, State (Arizona Administrative Rules) and other rules and regulations and statutes as applicable to individuals with serious mental illnesses.

4. Each person's Individual Service Plan (ISP) is a fluid document, identifying the type of services in which each consumer will participate in order to achieve the goal of recovery and move toward self-sufficiency.

5. Clinical teams will identify those services needed, but not currently available, on each individual's ISP, and the RBHA for Maricopa County will establish a process to aggregate information regarding those needs to be utilized later for planning and service development.

6. All staff involved in service delivery will be adequately informed regarding recovery from psychiatric disability, their clinical team roles, responsibilities and expectations and best practices for psychiatric rehabilitation.

7. The design for the system is flexible, assuring progressive moves of consumers from high levels of service to more independence, and that clinical teams are able to respond to changing consumer needs when there are crises and/or relapses, supporting the individual with the least restrictive services possible. Staff allow risk and "right to fail" as a natural part of human growth.

E. OVERVIEW – A MULTI-FACETED APPROACH

It is the goal of the Maricopa County RBHA that all consumers with a serious mental illness receiving case management services are served by a well functioning clinical team that effectively assists consumers in moving toward recovery.

This goal will be accomplished through the following objectives:

Objective One:

Enhance both the individual and team competency level of staff providing case management and clinical team services for adults with serious mental illness in Maricopa County.

Objective Two:

Increase the level of involvement and participation by external clinical team members (i.e., providers, state agency representatives, etc.), in accordance with AAC R9-21-101(10).

Objective Three:

Enhance the assessment and individual service planning process.

Objective Four:

Implement a clinical team demonstration project, designed to evaluate and establish a new structural model and configuration for clinical teams in Maricopa County.

III. OBJECTIVES

A. OBJECTIVE ONE

Enhance both the individual and team competency level of all staff providing case management and clinical team services for adults with serious mental illness in Maricopa County.

The Maricopa County RBHA, in its commitment to quality and improvement, devoted considerable effort over the past six months examining the functioning of clinical teams. This self-examination process included evaluation of functioning on a number of levels: individual employee performance, clinical team performance and overall system performance. The information gathered through this process, once analyzed, pointed to a number of key areas that must be addressed prior to the implementation of new "models" or configurations of case management teams. Primarily, the individual and team competency level of staff delivering case management and clinical team services must be improved.

In order to accomplish this key objective, the Maricopa County RBHA will employ the following strategies:

- Delineation of clinical team roles and responsibilities, including overall team roles, and detailed information regarding responsibilities ranging from coordination of care to paperwork completion (Section 1-1)

- Identification of both individual and team competencies and skills (Section 1-2)

- Initiation of a Performance Improvement Plan over the next two years, featuring provisions for staff competency determination through an individual employee competency testing program, individual staff performance monitoring, and specific training related to individual and team competencies; specific training, educational and informational activities for staff and consumers designed to foster consumer recovery from psychiatric illness; and, evaluate the functioning and measure the performance of clinical teams, using this information for continuous quality improvement (Section 1-3)

- Additional clinical team enhancement activities that are already underway. These activities range from improvements in clinical team services to consumer wellness education and information and are representative of the Maricopa County RBHA's continuing quest for quality improvement (Section 1-4)

The following presents the information described above. Specific, detailed implementation information is included at the end of this document (Section IV, page 61).

1-1. Roles and Responsibilities of Teams

Prior to development and implementation of any performance improvement plan, the roles and responsibilities of clinical teams must be clearly delineated. This section provides that delineation and will be integrated into the Clinical Team Resources Manual, a comprehensive policy, procedure and best practice manual for clinical teams in development.

A. Overall Team Roles

1. The team completes a differential diagnosis, identifies target symptoms and prodromal symptoms of relapse. Team members are involved in the process of gathering related information.

2. The team arranges for each consumer to obtain assessments of interests and abilities related to meaningful community activities, rehabilitation services and/or education. The team provides or arranges for consumers to find and maintain meaningful community activities, whether paid or unpaid. Each consumer's vocational or educational plan becomes part of his or her overall treatment plan.

3. The team arranges for and/or provides support, as needed, for activities of daily living for each consumer in community-based settings; These activities range from engagement, problem solving, side-by-side assistance, environmental adaptations, supervision and skills training.

4. The team assists consumers in developing the necessary skills to obtain basic necessities of daily life.

5. The team provides education, support and consultation to the consumers' families and other major supporters including education about mental illness and the role of the family in the therapeutic process, intervention to resolve conflict and ongoing collaboration with the consumer's consent.

6. The team identifies issues such as entitlements, and legal, advocacy, housing and physical health needs and documents them in the consumer's treatment plan. The team provides assistance in accessing these services and coordinates them with behavioral health needs and services.

7. The team conducts referrals for physical health services in a manner that assures consumers understand and can respond to requirements for accessing the needed service. If the consumer cannot respond independently, there is evidence of arrangements for assistance to the consumer to access services, including documented follow-up efforts.

8. Members of the consumer's clinical team keep each other informed of the consumer's needs and information relevant to the person's treatment, including information regarding their psychiatric status and history to the extent necessary for the facility or practitioner to treat the person successfully.

9. Integrated treatment is provided to individuals with co-occurring disorders. If integrated treatment is not available, the team will arrange joint planning and interventions with substance abuse providers for persons needing specialized services. The team is involved in the engagement, treatment and follow-up phases of substance abuse treatment.

10. Additionally, the team provides the following:

- Aggressive outreach and engagement in treatment when needed
- Sufficient assistance so that consumers receive all benefits for which they are entitled, and accurate and adequate information regarding the effect on benefits programs of participation in meaningful community activities, whether paid or unpaid
- All treatment is coordinated with all pertinent parties
- Consistent and ongoing engagement and encouragement to participate in meaningful community activities
- Education regarding peer supports, advocacy organizations, and community activities and resources
- Timely referrals to services as identified in the ISP
- Unmet needs are identified at the time of ISP development and reported to the RBHA.

B. Case Management Team Responsibilities

The following outlines key case management responsibilities:

1. Monitoring of Consumer Status and Progress

Monitoring of consumer status and progress, focusing upon target symptoms and prodromal symptoms of relapse, occurs through regular and ongoing contact with the consumer. The frequency and type of contact is determined during the treatment planning process, and is adjusted as needed, taking into account clinical need and consumer preference.

2. Coordination of Care

An important responsibility of the case management team is to coordinate care on the behalf of consumers so that treatment and support services most effectively meet consumers' needs. Coordination of care is required:

In Crisis Situations
- Demonstrate ability to identify, intervene and/or follow-up with a potential crisis or a crisis situation in a timely manner
- Provide information, backup and direct assistance to crisis programs and emergency personnel, including "on-call" availability of team staff to the Crisis System
- Provide follow-up with consumers after crisis situations, including contact with the consumer within 24 hours for Assertive and within the next business day for Supportive and Connective
- Provide and coordinate additional supports and services as needed to accommodate the consumer's behavioral health needs

With Primary Care Physicians (PCPs):
- At intake/enrollment into services
- At discharge/disenrollment from services
- At psychiatric hospitalization
- Inform PCPs of medication, medication changes and abnormal labs
- Request all assessments and laboratory results from the PCP when needed
- At all times of chronic illness or diagnosis of health concerns

With Hospitals and Jail Psychiatric Units

- Contact with Social Workers, Counselors and/or Jail Diversion personnel within 24 hours of admission or incarceration for members served by Assertive teams and by the next business day for members served by Supportive and Connective Teams
- Provide assessment information, service plans, medication sheets (and other information as needed) to the jail or psychiatric unit at time of admission by the Assertive teams and within one business day for Supportive/Connective teams
- Request staffing to discuss discharge/release plan and assist with discharge/release, including provision or coordination of needed transportation or other needed behavioral health services
- Follow-up appointment with the clinical team and prescriber per Arizona Administrative Code R9-21

With Providers and Other Involved Parties

- Provide coordination with social rehabilitation, vocational/employment and educational providers, housing and residential providers, crisis providers, family members and significant others
- Provide coordination between the ISP and each provider/program's treatment or service plan
- Obtain information about the consumer's course of treatment from each provider at the frequency needed to monitor consumer progress
- Participate in all provider staffing and service planning meetings. Obtain copies of provider service plans and enter as part of the clinical record
- Obtain input from providers and involved parties in the assessment and service planning process
- Provide education and support to family members and significant others regarding the consumer's diagnosis and treatment
- Provide a copy of the consumer's service plan to other involved provider agencies and involved parties
- Provide medication and laboratory information to residential and Independent Living Services providers or other caregivers involved with the consumer

3. Meetings, Staffing and Clinical Supervision

Meetings, staffing and clinical supervision are a critical part of effective communication and coordination. Formal communication protocols and work flows will be developed and refined throughout this implementation effort so that the right staff communicate the right information at the right time.

Below you will find outlined key communication requirements that have been identified, as well as a summary of clinical team meetings currently conducted by the RBHA.

Communication Requirements

- Participate in daily meetings, including discussion of consumers that are at risk and following up appropriately
- Team members participate in staffing for consumers for whom they are actively providing services
- Strive to ensure that Clinical Team members, as applicable for individual consumers, (Consumer, Psychiatrist, Nurse, Team Specialist, Vocational Rehabilitation Counselor, Provider, Guardian, Family, Payee, Behavioral Health Technician) actively participate in the ISP process. (Active participation can include providing feedback and recommendations for the plan, but does not necessarily mean that each person will attend a formal ISP meeting)
- Participate in Clinical Supervision per agency and A.A.C. R9-20 requirements, and discuss issues and concerns regarding consumer care and documentation process with supervisor
- Attend required training

4. Assessment and Treatment Planning

The goal of Assessment and Treatment Planning is to obtain a comprehensive understanding of the consumer's needs as well as an effective plan to address these needs is developed. Below you will find a description of case management team members' responsibilities as they relate to assessment and treatment planning.

- Provide ongoing assessment in order to determine target symptoms and prodromal symptoms of relapse, and service intensity needs
- Collaborate on the development and implementation of an integrated treatment plan based upon thorough and ongoing assessment
- Arrange for and/or provide additional assessments needed, including, but not limited to, vocational, nursing, educational and daily living skills assessments
- Actively involve the consumer, family members and other supports and service providers in a collaborative process of establishing, monitoring and refining the treatment plan
- Identify and access the full range of treatment and support services, including peer supports and those in the natural support system
- Use established tools, protocols and timelines for conducting assessments and establishing treatment plans

5. Paperwork Completion

Paperwork is a necessary part of ensuring that there is appropriate communication and coordination regarding consumer care as well as meeting regulatory and licensure requirements. Part of this initiative is to streamline paperwork requirements as much as possible to maximize team members direct service time with consumers. Minimum paperwork requirements defined in Arizona Administrative Code R9-21 and the Arizona Division of Behavioral Health Services Policies and Procedures will be evaluated and streamlined throughout implementation of this plan.

1-2. Competencies and Skills

This section of the plan describes the individual and team competencies needed to fully implement the functional criteria for clinical teams. The following competencies are based on those of the Mental Illness Substance Abuse (MISA) consortium. Appendix A, *Case Management and Clinical Services Team Cross Reference Chart*, reflects the cross-referencing of these competencies with the functional criteria in Appendix B, *Functional Criteria for Clinical Team Services.* As with the information contained in the previous section, this information was used to develop the Performance Improvement Plan, which follows in Section 1-3.

A. Individual Competencies

The following outlines the criteria needed for the delivery of effective case management services. While every team member will be expected to demonstrate familiarity with the following criteria, it is expected that at least one member of each team demonstrates expertise in the following criteria, thus contributing to the overall team competency in these areas.

1. Summary of Individual Competencies

a. Relational Skills (based in values and attitudes)

- Understanding of:
  - unconditional compassion
  - respect
  - flexibility
  - objectivity
  - sensitivity to persons with different disorders
  - characteristics and cultural backgrounds
  - maintenance of professional boundaries
  - patience and persistence in helping to establish and maintain person's motivation.
- Ability to work with individuals in a non-judgmental manner
- Ability to facilitate consumers, family members and other service providers to collaborate in service planning and provision, support and education
- Elicit consumer's viewpoint and validate strengths needed to cope with disorders
- Communicate with integrity and honesty, clearly and concisely and in a respectful manner to all team members.

b. Technical (Knowledge-Based) Skills

Familiarity with:

- Current DSM categories and diagnostic criteria, including criteria for Axis 1 and 2 disorders, i.e. psychotic, affective, anxiety, personality, substance-related disorders
- Psychoactive chemicals, including prescription, non-prescription and street drugs
- Signs and symptoms of potential medical complications associated with detoxification and use of psychotropic medications, including side effects of psychotropic medications, and appropriate interventions .

c. Assessment Skills

The ability to use a strengths-based interviewing and focus in the treatment process. Knowledge of the following components of assessment:

- Bio-psychosocial
- The ability to assess functional strengths and deficits related to human development phases, substance related and mental disorders
- Incorporation of information from all available sources including consumer, family, friends, past and current service providers
- Determination of risks for danger to self or other behaviors and determination of appropriate interventions when necessary
- Use of established criteria or tools for assessing acuity of symptoms and service needs
- Determination of special circumstances that may affect client's judgment, ability to participate in treatment planning, forensic/legal involvement.

d. Treatment Planning Skills

The ability to collaboratively develop and implement an integrated treatment plan by:

- Identifying target symptoms and prodromal symptoms of relapse
- Involving the person, family members, all service providers and other supports
- Addressing all disorders and basic needs in an integrated vs. Parallel manner
- Supporting the person's capacity to envision a positive personal future
- Utilizing a full range of treatment and support services, including case management and coordinated clinical teams, and including the most natural and least restrictive services deemed appropriate.

e. Treatment, Rehabilitation, and Recovery-Focused Skills

Engagement of the person and others regarding the following:

- Perceived effect of prescribed medications and any concerns
- Benefits of taking medications as prescribed; risks of not taking medications as prescribed or use of alcohol and/or street drugs.

Familiarity and use of intervention techniques, including:

- Those designed to aid in recovery of persons with traumatic histories and co-occurring disorders
- Motivational enhancements, behavioral contracting, empathic confrontation, cognitive-behavioral approaches to both treatment and relapse prevention, skills and social skills training, psycho-educational individual and group approaches, peer support and empowerment groups
- Those designed for persons in various states of recovery: engagement, persuasion, treatment issues, relapse prevention and those geared toward active and collaborative involvement by the person in their treatment
- Engagement in ongoing quality improvement efforts, including consumer and family satisfaction surveys, accurate reporting and use of outcome data, use of quality monitoring instruments, performance improvement plans.

f. Crisis Prevention and Intervention Skills

- Knowledge of crisis intervention theory and the Ability to identify a crisis in consistent terms and define it consistently to the Consumer, family and other caregivers.
- Ability to follow established protocols for preventing, intervening and stabilizing a crisis, including response to requests by and assisting crisis programs and emergency personnel in crisis situations.

- Familiarity with each assigned Consumer's crisis plan or ability to access the crisis plan and use the plan to respond to crisis situations.
- Demonstrated level of crisis prevention, intervention and stabilization skills.

g. Computer Literacy Skills and Recording/Entry of Information in MIS/Absolute Systems

Basic computer skills

- Turning on/off computer
- Logging in/out
- Trouble shooting
- Knowledge of contact for problems
- Saving information, etc.
- Ability to access data base information and record and update treatment plans including recording of:
  - treatment planning meetings
  - service referrals
  - assessment information and other required documentation (crisis plans, progress notes, special assistance, emergency contacts, crisis encounters and interventions, face sheet, appeals/grievances).
- Ability to access data base information for timely recording of prescribed medication including:
  - changes in medication
  - potential medical complications
  - possible negative responses to drugs
  - medication and medical history
  - benefits of medications
  - pharmacy information
  - medication authorizations/requests for authorization.
- Ability to access data base information for request for authorizations of services and medications including:
  - approval/denial of authorizations for medications and services
  - notification of appeal rights and efforts to resolve disputes
  - level of care information.
- Accessing data base information for documentation of other involved agency/family communication and collaborative efforts involved in service planning

h. Administrative/Supervisory

- Ability to generate and analyze reports in a timely manner. Prepare corrective actions (individual and system) and conduct follow-up on implementation/reporting of systems issues. Reports to include:
  - timeliness of documentation
  - client progress/outcomes
  - service availability and utilization
  - trends, caseload size, CFR data, etc.
- Preparing corrective action and ensuring follow-up if identified issues
- Reporting related to service provision including responsiveness of team-connect/combine with T-9
- Informing individuals of ways to become more involved through CAB, CAC, etc.
- Clinical and Administrative Skills
- Clinical supervision occurs for each team member in accordance with agency and OBHL requirements
- Demonstration of supervision, ability to train, observe performance (supervised performance/reflective supervision), ability to analyze staff performance and provide feedback
- Ability to convey new information, changes in policies and procedures in a timely and organized manner, meeting facilitation, and obtainment of consensus, skills in team building activities.

2. Policies and Procedures to Support the Competencies

The policies and procedures of the Department of Health Services/Division of Behavioral Health Services, the RBHA (The RBHA for Maricopa County) and Alternative Behavioral Services (Maricopa County case management provider) were reviewed to determine if they support the newly defined well functioning case management team. In those cases where there was not a policy or procedure to support the team, new policies and procedures will be created. All policies and procedures will be contained in the Clinical Team Resources Manual.

B. Team Competencies

The following competencies are those that are necessary for a well functioning team to collectively possess and demonstrate. These competencies are not identified with one particular team member, but with the team as a whole and are essential to the overall team performance.

1. Summary of Team Competencies

- Shared vision, commitment and philosophy regarding the delivery of services to individuals with a serious mental illness including:
  - strengths model
  - recovery (including high expectations of consumers, maintaining an attitude of hope and using "people first" language)
  - involvement of the consumer and family in service planning process
  - shared responsibility and decision making among clinical team members
  - treatment for dual diagnosis/co-occurring disorders
  - importance of providing services in the community
  - encouraging and educating consumers and family members/care givers regarding organizations and groups that provide peer support, advocacy and education of mental health issues
- Ability to identify at risk members and how to prioritize clinical team member's time, appointment availability and resources:
  - To manage (tracking) case loads (ability to be flexible with schedule)
  - To work together as a team to meet the needs of their clients
- Commitment to the individual–expectations will be realistic and individuals will be provided a welcoming environment initially and at all times thereafter. Efforts will be made to engage the individual in treatment and outreach/follow up provided when needed
- Crisis Capabilities:
  - Knowledge of how to develop a crisis plan inclusive of all issues related to the individual's functioning
  - Identification of At-Risk/High Profile Consumers and familiarity with their crisis plans
  - Ability to identify a crisis in consistent terms and define it consistently to the Consumer, family and other caregivers.
  - Ability to follow established protocols for preventing, intervening and stabilizing a crisis, including response to requests by and assisting crisis programs and emergency personnel in crisis situations.
  - Familiarity with each assigned Consumer's crisis plan or ability to access the crisis plan and use the plan to respond to crisis situations.
  - Demonstrated level of crisis prevention, intervention and stabilization skills.

- Multidisciplinary approach with shared responsibility (i.e. with agencies/systems such as educational, criminal justice, protective services, RSA, DDD, ALTCS, etc.):

  - Treatment/Service plan development and monitoring is coordinated among team members– incorporates recommendations, assessment information and identifies the roles/responsibilities of each team member
  - Multi-agency coordination and encourage involvement in the ISP process as needed
- Sharing knowledge of resources:
  - Team has expertise (either on the team or available to add to team when needed) in areas such as vocational services, housing, substance abuse/dual diagnosis, benefits, community resources or as identified as needed through the assessment process)
  - Back-up covering or ensuring coverage of responsibilities when members absent/unavailable
  - Shared multi-disciplinary approach to problem solving, treatment planning, and decision making (all members contribute input, ideas and information to develop consensus–buy-in from all parties and shared responsibility)
- Staffing Intensity and Location of Service:
  - Ability to identify level of care determinations based on an individual's functioning on a continuous basis and adjust services, including team composition, staff to consumer ratio and the intensity of services, accordingly
  - Ability to modify team composition and/or services based on the changing needs of the consumer. Appropriately identify when a consumer should be transferred to a new team such as when the individual's needs change over an extended period of time that can not be met by the team adjusting current service levels
  - Frequency, type and duration of contacts are based on the individuals' need and provided in the community whenever possible
  - Ability to identify and secure services needed that cannot be provided by the team
- Open and Clear Communication:
  - Knowledge and use of consensus building approaches when making decisions
  - Clear understanding of meeting goals and Team supports an open environment in which input and ideas are encouraged and responsibility for decision making is shared among team members
  - When barriers are encountered team members coordinate efforts to explore additional resources/options and forward to supervisors/administration in situations that are "system " problems
  - Culture supports creativity, risk taking, service innovations and openness to new ideas on the part of all team members
- Planning incorporates ethnic/cultural sensitivity:
  - Identification of need for and coordination of interpreters when needed
  - Encourages an environment which respects individuals, ethnic and cultural diversity
  - Team recognizes cultural or ethnic issues that may impact service planning and/or delivery and a plan reflects approaches to address issues/barriers

2. Policies and Procedures to Support the Competencies

The policies and procedures of the Department of Health Services/Division of Behavioral Health Services, the RBHA (The RBHA for Maricopa County) were reviewed to determine if they support the newly defined well functioning case management team. In those cases where there was not a policy or procedure to support the team, they will be developed. All policies and procedures will be maintained in the Clinical Team Resources Manual.

1-3. Performance Improvement Plan

This section includes an overview of the Performance Improvement activities for the Maricopa County RBHA. This ambitious plan, which will be carried out over the next two years, establishes the foundation upon which all system enhancements and improvements in the future will be built and evaluated. The Performance Improvement Plan encompasses the visions and missions of both the RBHA and ADHS/DBHS, and is designed to equip the staff providing consumer care with the knowledge and skill necessary to provide quality care and foster consumer recovery and rehabilitation. The Performance Improvement Plan was developed utilizing information previously described regarding the roles and responsibilities of clinical teams, as well as individual and team competencies, and includes provision for:

- Establishing a one-time baseline determination of individual and team competencies
- Providing information necessary to improve individual and team competencies, as well as building a foundation of knowledge and skill regarding recovery and psychiatric rehabilitation
- Evaluating individual, team and system performance over time, ensuring individual staff accountability at all levels

The Maricopa County RBHA performance improvement process is designed to integrate several departments into a joint effort that will equip new and existing employees to successfully perform their duties and continuously support them in their performance as they provide services to the Consumers. The departments involved include: Quality Improvement, Grievance and Appeals, Service Integration, Risk Management, Clinical, Human Resources, Training, Regulatory and Compliance, Nursing, Medical Director, MIS and Site Administration. These departments' efforts are coordinated through the Training and Quality Management departments.

A. Determination of required knowledge and the effective implementation of requirements into work performance

The Maricopa County RBHA has initiated a two-year plan to conduct ongoing determination of staff knowledge and competency, and to monitor the impact of training on work performance. Staff involved in the determination process include representatives from Training, Regulatory and Compliance, Clinical Directors, Quality Improvement, Nursing Director and Assistant Directors and Assistant Medical Director. A team of representatives from these disciplines will conduct staff specific audits, on a clinic by clinic basis, utilizing established protocols. These staff will participate in a process whereby audit tools and process are clearly defined and inter-rater reliability is established.

This process includes:

Phase I (April 2000 – May, 2001)

1) Testing for baseline knowledge of policies, procedures and the requirements of fully functioning clinical teams;

2) Assessment of employee integration of those requirements into work performance through the following: clinical record reviews, focused audits and direct observation.

Individual and or Team audits will assess each position's performance:

- Prescriber (MD, DO, PA, NP)
- Psychiatric Nurse
- Clinical Care Coordinator/Lead Clinician/Mental Health Professional
- Clinical Lead
- Case Manager/Bachelor's Level Mental Health Worker
- Paraprofessional Mental Health Worker
- Site Manager/Team Coordinator

3.) Formal training, supervision, or individual mentoring will be required for each employee lacking knowledge or skill in each competency area (described in section B, below).

Phase II: (April 2001 – May 2002)

1.) Implement ongoing auditing process of team performance.

2.) Repeat assessment of employee integration of competency knowledge into work performance;

3.) Additional competency-related training, supervision, or individual mentoring.

The intent of this process is to build competency of all staff during the initial round of training. However, due to sheer numbers of employees, and the need for shifts in "culture" at all levels, it is expected there will be need for a second round of training and testing until all staff reach anticipated levels of competency.

Section B

Following is a grid including the training/competency topics, and projected competency determination and training dates. These dates are subject to modification based on implementation experience. The column identified as "Training Activities" identifies the dates that intensive training will be provided to assure all clinical employees have received the training, unless previously determined to be competent in the identified area. However, it is not the intent to wait until those dates to begin offering the training. The majority of these training topics are either currently being offered or will be offered prior to those final training activity dates.

Topics	Testing of policy/ protocols etc:	Auditing of employee performance	Training Activities
Core Competencies Phase 1 Grievance and appeals Confidentiality , Duty to report abuse, neglect, and exploitation. Documentation requirements Home visit guidelines, assisted living req., and proactive case management. Discharge planning Outreach and engagement Discharge/case closure Transfer process	April 10, 2000 to April 21, 2000	August to December 2000	December 2000 to present. (ongoing)

Case Management and Clinical Team Services Plan
Arizona Department of Health Services/Division of Behavioral Health Services

Topics	Testing of policy/ protocols etc:	Auditing of employee performance	Training Activities
Supervisory Training Administrative Supervision Site Management Training Clinical Supervision Training	No pretesting will occur, although post-testing will occur after training sessions.	No pre-auditing will occur although ongoing auditing will occur through QI activities.	May 2001 to present (ongoing)
Core Competencies Phase 2 Assessments/ CGI/ ALFA Individual Service Planning Service Implementation/Delivery Coordination of Care Community Resources Crisis System Crisis Prevention, Intervention and Stabilization Techniques Managed Care requirements Ethics and Boundaries Informed Consent for Medications Side Effects, Effectiveness and Concerns of medications addressed All team members assess and document symptoms, behavior and side effects and assist in consumer symptom and side effect education. M Cultural Competence DSM IV/Neurobiological Disorders Pharmacotherapy Co-Occurring Disorders Signs and Symptoms of potential medical complications/detoxification Psychoactive chemicals Benefits/Entitlements	No pretesting will occur, although post-testing will occur after training sessions.		December 2000 to present. (ongoing)

Topics	Testing of policy/ protocols etc:	Auditing of employee performance	Training Activities
Core Competency Phase 3 WRAP Plans and Consumer self-monitoring and symptom reduction techniques Family, Caregiver and Other Supports Education Familiarity and use of intervention techniques designed to aid in recovery of persons with traumatic histories and co-occurring disorders Familiarity and use (when appropriate) of intervention techniques Including: motivational enhancements,behavioral contracting, Empathic confrontation, cognitive behavioral approaches to both Treatment and relapse prevention, skills and social skills training, Psychoeducational approaches, peer support and empowerment Groups Quality Management/Quality Improvement processes	No pre-testing will occur although post-testing to training will occur	No pre-auditing to training will occur, although auditing following training will be incorporated into QI activities	June 2001 to June 2002 (ongoing)
Medical Staff Specific Training Medication Prescription and review per policy Medication storage, tracking, and disposal Informed consent for medications Coordination of Care with Health care Providers			

Ongoing determination of clinical staff core competency:

Clinical team functioning and competency criteria will be integrated into each employee's performance appraisal. For all clinical staff positions, competency determination will be assessed at intervals based on their date of hire. All employees will have competency determination assessed at the tenth month of their first year of employment and annually each year thereafter through standardized protocol. Results will be utilized for development of staff specific training and education planning identified to elevate needed areas of competency.

B. Clinical Team Training and Education

The Maricopa County RBHA provides a structured orientation for all employees. The new employee orientation program consists of two phases focused on RBHA organization and department/site orientation. All new employees are required to complete both phases of the program. General clinical orientation is provided to all clinic-based staff.

The Maricopa County RBHA also provides ongoing training opportunities and requirements for all employees to re-orient them to policies and procedures as they apply to both the employee and the consumer, so that employees remain abreast of policies and procedures as they relate to their jobs and their roles in the Organization, and to continue to promote quality work performance.

This section includes schemata of the core curriculum training for fully functioning clinical teams as well as specialized training required for each staff member of Assertive, Supportive and Connective Treatment teams, described later in this document. Core Curriculum will be provided by module instruction. Skill Development training activities will follow the core curriculum with specialized instruction, including experiential learning, mentoring, 1:1 instruction (as needed), and clinical supervision as part of the training continuum. Training and education activities will be held on a basis frequent enough to offer all

employees opportunity for participation. Clinical team members will be provided with opportunities to participate in additional educational, informational and wellness programs offered in the community or by other organizations.

Although not included in this document, the RBHA maintains a matrix of the training modules that will be used for the clinical team training. The Matrix identifies a cross-reference of module title, corresponding class title, competencies and skills and the functional criteria for the clinical team.

Case Management and Clinical Team Training

CORE COMPETENCY MODULES

- ***Recovery and Rehabilitation***
- ***Best Practices in Psychosocial Rehabilitation***
- ***Engaging/Supporting Consumers in meaningful community activities and employment***
- ***Exit Stipulation***
- ***Individual Service Planning***
- ***Rights of Persons with SMI***
- ***Confidentiality***
- ***Grievance and Appeal***
- ***Duty to Protect, Warn and Advocate***
- ***Coordination of Care (PCP,other agencies)***
- ***Behavioral Health Record Documentation***
- ***Ethics and Boundaries***
- ***Risk Management/Incident Accident Reporting***
- ***Community Resources***
- ***Service Planning Guidelines***
- ***Assessment Processes; Use of Assessment Tools***
- ***Clinical Interviewing/Effective Engagement and Communication Skills***
- ***DSM-IV/Neurobiological Disorders***
- ***Psychopharmacology***
- ***Crisis Prevention and Intervention***
- ***Roles and Responsibilities of the Clinical Team***
- ***Court Ordered Evaluation and Treatment***
- ***Best Practices in the Treatment of Co-Occurring Disorders***
- ***Intervention Techniques for: Persons in Various States of Recovery; Persons with Traumatic Histories***
- ***General Intervention Techniques: motivational enhancement, behavioral contracting, cognitive behavioral approaches***
- ***Continuous Quality Improvement***
- ***Managed Care***

Fully Functioning Clinical Teams

Assertive Treatment Services Team

- *Assertive Treatment Program*
- *Crisis Identification & Intervention*
- *Conflict Resolution*
- *Outreach and Engagement*
- *Family and Consumer Education*
- *Activities of Daily Living Intervention*
- *Co-Dependency*
- *Housing*
- *Family and Consumer Education*
- *Home Visits/Community Based Contacts and Linkages*
- *Social Skills Training and Development*
- *Supportive Counseling*
- *Relapse Prevention*

Supportive Treatment Services Team

- *Supportive Treatment Program*
- *Conflict Resolution*
- *Supportive Counseling*
- *Family and Consumer Education*
- *Relapse Prevention*
- *Outreach and Engagement*
- *Home Visits/Community Based Contacts and Linkages*

Connective Services Treatment Team

- *Connective Treatment Program*
- *Coordination of Care/Building a Network*
- *Community Linkages*
- *Relapse Prevention*
- *Family Education*
- *Understanding Recovery & Graduation*

Additional Training for Housing Specialists	Additional Training Topics for the Substance Abuse Specialist	Additional Training Topics for the Rehabilitation Specialist
• Housing Programs: Section 8; 202, 236; Shelter Plus Care; Supportive Housing Programs; Shelters: State and Federal laws, rules and requirements; application process • Landlord Tenant Act • Assessment skills to determine appropriate type of housing • Independent Living Skills • Home Visit • Arnold v. Sarn requirements • Fair Market Rent • Housing Quality Standards • Mediation of Complaints • Americans with Disabilities Act • Housing Assistance Payments • Behavioral Health Residential programs • Experiential Learning will be done through a variety of shadowing/mentoring activities with the RBHA Housing Staff, including participation in staffing, mediation efforts, home visit activities, etc.	While all staff will receive training in Co-Occurring Disorders, the Substance Abuse Specialist will receive additional training and demonstrate expertise in these areas, based on the competencies and training recommendations in the Arizona Integrated Treatment Consensus Panel Implementation Plan and the related Training workgroup and modules under development: • Relational Skills • Technical (Knowledge-Based) Skills • Assessment Skills, including use of specialized assessment tools for persons with Co-occurring disorders • Treatment Planning Skills, focused on the planning and delivery of integrated services for persons with Co-occurring disorders • Treatment, Rehabilitation and Recovery-Focused Skills for persons with Co-occurring Disorders.	The Maricopa County Recovery and Rehabilitation Information, Education and Training Plan, required by the Superior Court, presents an overview of specific training and education to be presented surrounding rehabilitation. Rehabilitation Specialists training will include, but is not limited to: • Best Practices in Psychiatric and Vocational Rehabilitation • Effective rehabilitation and employment strategies • Community rehabilitation and meaningful activity resources • Arizona's Federal VR Program services, policies, procedures and limitations • Effect of work and meaningful community activities on benefits programs • Maricopa County Vocational Services ISA requirements and expectations.

C. Rehabilitation and Recovery Modules

The Maricopa County Strategic Plan for Employment and Rehabilitation required the completion of a three-year comprehensive training plan designed to establish a basic foundation of knowledge and skill surrounding recovery and psychiatric rehabilitation. This plan, entitled "The Maricopa County Recovery and Rehabilitation Information, Education and Training Plan", includes the following goals:

- Informing all Clinical Team staff, Consumers, Providers and other stakeholders of intended shifts and modifications to the system
- Establishing a basic foundation of knowledge regarding recovery from psychiatric illness, including best practices for psychiatric rehabilitation within the service delivery system
- Ensuring ongoing technical assistance and support is available to clinical team staff, sufficient to ensure success.

The Recovery and Rehabilitation Training Plan was developed by a multidisciplinary group of representatives from the RBHA, Providers, State Agencies and Consumers. The focus of this effort, while certainly with a primary eye toward improved clinical team functioning, expands the scope of training activities to include Network Providers (such as rehabilitation, residential and substance abuse providers) and State Agencies (such as RSA).

This work group recommended delivery of the following three core units:

- Recovery and Rehabilitation:
  An overview of the basic concepts and beliefs associated with recovery from psychiatric illness. Presents an introduction to psychiatric rehabilitation principles

- Best Practices in Psychiatric Rehabilitation
  Presents an overview of principles and best practices of psychiatric rehabilitation, and policies and requirements associated with consumer participation in meaningful community activities, whether paid or unpaid

- Engaging and Supporting Consumers in Meaningful Community Activities and Employment
  Skills and practice surrounding engagement of consumers in assessment of rehabilitation needs and desires, identifying goals, selecting services, evaluation and planning tools, and the supports necessary for consumer success

These three units will be delivered throughout Maricopa County (as described in the Rehabilitation and Recovery Education, Information and Training Plan) over the next 18 months.

D. Consumer/Family Member/Caregiver Education

This training program is designed to assist in the enhanced delivery of clinical services, as well as foster Consumer recovery from psychiatric illness. As identified in the Strategic Plan for Employment and Rehabilitation, Clinical Staff will continuously offer a program of wellness information and education. The RBHA recognizes the value of education and information in assisting Consumers in achieving and maintaining psychiatric stability, integrating into the community and moving toward self-sufficiency. These services can most efficiently, and cost-effectively, be provided by Clinical Team staff and, in many cases, Consumers, with support from Clinical Training Specialist staff. Curricula and written information will be tailored to meet Consumer's special needs. This program of education and information will include, but is not limited to the following:

- Disability awareness and adjustment education to assist Consumers in understanding and coping with the cyclical nature of Serious Mental Illness, its symptoms, resulting functional limitations and impact on community integration
- Education about mental illness; information surrounding the medical implications of mental illness, access to health care, psychiatric medications and potential medication benefits and side effects
- Information regarding the effect of work and community activities on benefits programs such as SSI, SSDI, Food Stamps, AHCCCS, TANF, housing, etc.
- Orientation to the "world of work", including the impact of work and meaningful community activities on individual lifestyles
- Role of the family/caregiver in the therapeutic process
- Family members will be referred to local family support groups such as Arizona Alliance for the Mentally Ill for educational and supportive functions

E. Quality Management and Quality Improvement Activities

By June 1, 2000, the Maricopa County RBHA will implement a monthly program designed to provide a rapid and ongoing assessment of clinical team functioning by initiating "Team Score Cards", as follows:

I. Team Score Cards: the following are examples of audit processes that will occur on a quarterly or annual basis, as appropriate. As a result of audit outcomes, each clinical team will receive a performance score in each of the identified areas. Necessary performance improvement plans will be developed and implemented as needed, based on the scores. As specific areas reach performance thresholds, these intensive audits will be discontinued and additional topics may be added.

1. Clinical Case Audit will be initially completed on a minimum of two cases per team, per month for the following sample populations:
   a. High Risk Consumers
   b. Priority Population Consumers.

2. Critical Incident Analysis and Review (Critical Incident is defined as: "A Consumer-related incident of: Death related to Suicide or Homicide; Homicide by a Consumer; Homicide and Suicide Attempt; Allegations of Civil Rights Allegations; and Allegations of Physical or Sexual Assault")
   a. A quarterly report will be generated and sorted by type of incident, by clinic. This report will be analyzed for trends.
   b. A Critical Incident Review will occur for all Critical Incidents and a follow up audit will occur to monitor for:
      i. compliance with the required process per policy
      ii. accurate and timely completion of corrective action/performance improvement plans.

3. Discharge Planning from inpatient and jail psychiatric unit settings:
   a. Utilizing the RBHA reports regarding discharge planning and jail information, discharges from inpatient and psychiatric jail units will be sorted by clinic. From this, a sample will be identified for audit to determine:
      i. adequacy of services, supports and interventions provided prior to the inpatient or jail admission, to try to prevent the admission
      ii. adequacy and timeliness of discharge planning
      iii. implementation of the discharge plan following discharge.

4. Consumer Contacts: Consumer contacts, tracked through the ABSolute system, will be monitored to determine compliance with internal standards for type and frequency of contacts.

5. Completion of required clinical documentation will be monitored through the ABSolute On-line Audit Summary.

6. Clinical Supervision will be monitored through:
   a. direct observation of clinical supervision sessions
   b. review of the clinical supervision documentation to determine adequacy of documentation
   c. review of clinical supervision documentation submission reports (reflects numbers of hours of clinical supervision provided).

7. Daily Clinical Team Meeting will be assessed for adequacy through:
   a. direct observation and scoring using a Meeting Checklist
   b. check of entries into ABSolute for each monitored meeting, to assure entry of information into ABSolute per Daily Meeting policy.

8. Clinical Staffings will be monitored through:
   a. direct observation
   b. review of documentation
   c. determination of involvement of required parties.

9. Morale/Employee Satisfaction will be addressed through
   a. employee satisfaction survey
   b. analysis of employee exit interviews.

10. Staff attendance at Trainings, both required and optional will be tracked.

11. "Focus Audits" will be completed on a different priority topic each quarter. Prioritized audits topics include:
   a. ABS staff attendance at external agency staffings, prioritizing inpatient and residential settings
   b. Outreach and Engagement activities on "Missing in Action" Consumers. Sample to be identified based on Consumers who had no contact within the past three months
   c. Supervisory Care Homes: are adequate home visits being done, assessments of the Consumer and facility being completed; does the ISP address what the team is doing to get the person into an alternative setting; are the specific activities to get the person into an alternative setting occurring
   d. Involvement of/coordination with relevant parties in the Consumer's life:
      i. family members
      ii. guardian
      iii. PCP
      iv. RSA and rehabilitation and vocational providers
      v. Parole/Probation
      vi. DDD
      vii. Protective Services
   e. Court Ordered Treatment: assessment of patterns of COT implementation; presence of adequate Forced Medication Plan
   f. Court Ordered Treatment: do staffings occur 30 days prior to termination of COT, with adequate plans in place
   g. Special Assistance: are Consumers assessed, accurately identified and policy being followed
   h. Informed Consent for Medication.

   Additional focus audits will occur as the need is identified.

II. Clinic Score Cards will be issued to each clinic location. As a result of audit outcomes, each clinic site will receive a performance score in each of the identified areas. Necessary performance improvement plans will be developed and implemented as needed based on the scores. As specific areas reach performance thresholds, the intensive audit activities will be discontinued and additional topics may be added.

1. Facility visits will occur on a quarterly basis by the Site Administrators to monitor the following:
   - *i.* assessment of the physical condition of the facility
   - *ii.* observation of site-wide meeting to assure adequate dissemination of information
   - *iii.* discussion with staff to determine if information has been correctly disseminated to all levels of staff
   - *iv.* observation of staff/consumer interaction

2. Special audit activity outcomes

3. Customer Service reports:
   - *i.* complaints through the RBHA Customer Service department
   - *ii.* grievance and appeal data
   - *iii.* internal complaint process
   - *iv.* suggestion boxes

4. Staff Turnover:
   - *i.* percentage
   - *ii.* number of days from employee resignation to filling of position

5. Medical Records filing (according to policy)

6. Medical staff scheduling/availability

7. Overtime use as related to productivity levels

8. Medical staff productivity rates

9. Timeliness of following requirements:
   - *i.* Incident/Accident Reports
   - *ii.* Corrective Action responses and completion
   - *iii.* Status reports
   - *iv.* Caseload distribution

F. Outcome Measures and Determination

Priority Outcomes

Each year, the RBHA will identify a set of priority measures to measure performance of the clinical teams. It is expected these priority measures will change from year to year, as the performance of the clinical teams will be impacted by the enhanced clinical team services activities.

Compliance with Exit Stipulation Performance Indicators

The following key performance indicators, which are used by the Office of the Monitor for assessing the requirements of the Arnold v. Sarn Exit Stipulation will also be used in evaluating the SMI Case Management and Clinical Services Program:

Criterion 01: Priority clients have case managers.

Criterion 02: Except in the unusual circumstance where the person is properly assigned to the case coordination model, priority clients have clinical teams which include the client, nurse, physician, case manager and vocational specialist unless employment has been determined by the team and the client no longer to be an issue.

Criterion 03A: Within 90 days of a determination of eligibility, priority clients whose needs require extended ISPs have extended ISPs, with a functional assessment and a long term view.

Criterion 03B: Within 90 days of a determination of eligibility, priority clients whose needs require extended ISPs have extended ISPs, with a functional assessment and a long term view.

Criterion 04: Priority clients shall have periodic reviews at least every six months.

Criterion 05A: Wherever there is a substantial reduction of services, a substantial modification of a residential setting or day/vocational program, or a termination of services, class members ISPs are modified with the client's consent or consistent with ISP rules.

Criterion 05B: Wherever there is a substantial reduction of services, a substantial modification of a residential setting or day/vocational program, or a termination of services, class members ISPs are modified with the client's consent or consistent with ISP rules.

Criterion 06: Class members are informed of their right to appeal eligibility and treatment decisions.

Criterion 07: The needs of priority clients are met consistent with their ISP.

Criterion 08: The needs of class members are substantially met, consistent with their ISP, if one exists, their treatment plan, if no ISP is available, or the Special Needs Treatment Plan for inmates in the Jail.

Criterion 09: Class members participate in the planning and development of their ISP, if one exists, their treatment plan, if no ISP is available, or the Special Needs Treatment Plan for inmates in the Jail.

Criterion 10: Class members in need of special assistance are offered or provided reasonable assistance by ADHS or the RBHA in the ISP and grievance process.

Criterion 11 A: Class member's charts show documentation of adequate informed consent to medication, ECT, and surgically-related procedures to address mental health conditions.

Criterion 11 B: Class member's charts show documentation of adequate informed consent to medication, ECT, and surgically-related procedures to address mental health conditions.

Criterion 12A: Class members, if still remaining for more than seven days in inpatient treatment settings, have an ITDP by the tenth day which is derived from their ISP or from the treatment plan if one exists.

Criterion 12B: Class members, if still remaining for more than seven days in in patient treatment settings, have an ITDP by the tenth day which is derived from their ISP or from the treatment plan if one exists.

Criterion 14: RBHA and provider staff serving class members receive adequate orientation and training.

Criterion 15A: All programs funded by ADHS substantially provide services which are consistent with principles 2 (respect) and 5 (humane treatment) of AAC R9-21-103.

Criterion 15B: 24-hour staffed residential treatment programs, funded by ADHS, ASH and inpatient settings to the extent relevant or practical, and all day/vocational programs substantially provide services which are consistent with principles 3 (self-determination) and 10 (integration) of AAC R9-21-103.

Criterion 16: ADHS or its designee shall investigate reports of abuse and neglect, shall review death reports generated by the RBHA or providers, and shall investigate deaths when required.

Criterion 17: ADHS tracks and trends grievance/appeal requests for investigation information to determine whether appeals or grievances are resolved in a timely manner and whether recommendations or decisions are implemented.

Compliance with Maricopa County RBHA Provider Monitoring Requirements

All programs established as a part of the SMI Case Management and Clinical Services Program will be required to comply with the Maricopa County RBHA Provider Requirements for Quality Management, dated January 1, 2000, and will be required to participate in the Maricopa County RBHA Provider Monitoring Plan, dated January 1, 2000.

The Provider Requirements for Quality Management encompass performance in the following areas:

- Quality Management Program
- Utilization Management Program
- Training Program
- Risk Management Program
- Grievance and Appeal Program
- Access to Care
- Assessment and Service Planning
- Member Satisfaction Surveys
- The Provider Monitoring Plan includes the following components:
- Case File Reviews
- Site Visits
- Contract Compliance Audit
- Program Audit
- Quality Management Review
- SMI Program Review
- Training Review
- Appointment Availability Monitoring.

B. OBJECTIVE TWO

Increase the level of involvement and participation by external clinical team members (i.e., providers, state agency representatives, etc.), in accordance with AAC R9-21-101(10).

In the recent past, a number of initiatives examining issues within the clinical team services system have identified concerns regarding inclusion of non-RBHA staff as members of each consumer's clinical team. Numerous key life areas, such as rehabilitation, residential and substance abuse, are often identified as requiring significant attention through each consumer's ISP. It is critical that staff (and others) representing and providing services in these areas be included as full members of clinical teams.

In keeping with the overall goal of enhancing clinical team and case management services, and ensuring the existence of fully functioning teams, the Maricopa County RBHA will employ the following strategies to increase the level of involvement and participation by all clinical team members:

- Provide training to staff (as part of core competency training) regarding the "make-up" of clinical teams and requirements surrounding non-RBHA staff inclusion as team members
- Establish an "Enhanced Clinical Services Advisory Panel", including key community stakeholders such as consumers, community advocates, representatives from Network Providers and State agencies, etc. Panel membership will be sufficient to represent a wide range of expertise, disciplines and system areas, including clinical, vocational, rehabilitation, housing, residential, and substance abuse. The panel will be charged with the following tasks:
  - identify strategies to bridge community resource gaps
  - create avenues to increase communication between all clinical team members
  - identify strategies for inclusion of all appropriate Providers, State Agencies, Family Members and other stakeholders in each consumer's clinical team

  This panel will meet at least on a quarterly basis, and will be established by July 31, 2000.
- Review and modify, as appropriate, RBHA policies, procedures and Program Service Guidelines regarding inclusion of, and participation by, clinical team members; a process currently underway. Policies and Procedures and Program Service Guidelines will be reviewed by the above Panel, and modified as appropriate, based upon panel recommendations.

C. OBJECTIVE THREE

Enhance the assessment and individual service planning process.

The initial completion, and ongoing process, of a consumer's assessment is crucial to the overall goal of consumer recovery. The assessment process ensures that necessary and sufficient information is available to both consumers and professionals to develop effective service goals, plans and strategies. The current process is often described as long and cumbersome, both for staff and consumers. In order to ensure that the assessment and ISP process (and associated tools) assist clinical teams to function, based upon fully functioning team criteria, the RBHA will employ the following strategies:

- Establish a work group in collaboration with DBHS. This group, consisting of a cross-section of mental health and rehabilitation professionals, will identify the most appropriate assessment process and tools to be utilized to assist consumer development of ISPs, including career and rehabilitation plans.
- Modify, as appropriate, the ISP tool, ensuring it is sufficient to meet the needs of fully functioning clinical teams, fulfills the principles and values of the Maricopa County Plan for Employment and Rehabilitation and meets outcome guidelines established within the plan. The effort will include participants from the RBHA and ADHS as well as consumers.
- Create a best practices, policies and procedures guide for clinical team staff in their proper use of these assessments.

These activities will be completed by September 30, 2000

D. OBJECTIVE FOUR

Implement a clinical team demonstration project, designed to evaluate and establish a new structural model and configuration for clinical teams in Maricopa County.

In addition to the previously described activities designed to ensure existence of clinical teams that operate based upon fully functioning clinical team criteria, the RBHA intends to make significant changes in the structure and configuration of clinical teams over the next two years. These changes will be contingent upon available funding. To achieve this goal, the RBHA will:

- Delineate three service and resource intensities (Section 4-1)
- Identify criteria for consumer assignment to service intensity (Section 4-2)
- Create protocol for changes in intensity of service (Section 4-3)
- Organize and evaluate four clinical teams based upon the description of "Supportive Treatment", including identified specialists in the areas of rehabilitation, housing and substance abuse; one clinical team based upon the description of "Connective Treatment"; and, one clinical team based upon the description of "Assertive Treatment" (Section 4-4).

4-1. Three Service and Resource Intensities

This section gives an overview of the three intensities of service and resource intensity for case management. It provides a general description and discussion related to target population, service provision, and team members for Assertive, Supportive, and Connective intensities of case management service, and includes a summary chart for comparison. In section 42 that follows, you will find a description for the method of assigning consumers to these levels based on clinical need and consumer preference. Implementation of these three service intensities is described in the Section IV, Plan for Implementation.

It is important for the reader to note that, for reasons of clarity and continuity, the following descriptions are offered in order of intensity, as opposed to order of implementation.

A. Assertive Case Management Treatment

1. ***General Description***

Assertive Treatment may be defined as "an array of services that are provided by community-based, mobile mental health treatment teams to seriously mentally ill persons in vivo, seven days a week, 24 hours a day. Team composition consists of a Team Coordinator, Psychiatrist, Nurses, Team Specialists (rehabilitation, employment, housing, independent living, substance abuse), Behavioral Health Technicians, and others.

In this mode, actual services (as well as person-centered learning and coordination of services) are provided at very low staff-to-client ratios that allow continuous contact with the individual. Average caseload size is 12, with additional specialists and representatives of other providers joining the team to meet specific needs of individuals.

Assertive Treatment is based upon the Assertive Community Treatment (ACT) model, which has been widely embraced over the past 10 years by the mental health community, especially in the United States and Canada. Initiated nearly 25 years ago as a pilot project in Madison, WI, the ACT model is clearly one of the most researched models of community psychiatry, with volumes of documentation demonstrating its effectiveness. ACT has been fully replicated by Mental Health Departments in several states, including Wisconsin, Michigan and Rhode Island, and is being studied or piloted for statewide implementation in a host of others.

This model of services offers comprehensive, community based treatment and has been found to decrease hospitalization time, facilitate community living and foster psychosocial rehabilitation. It differs from "traditional" case management in that it does not involve "linkage" or "brokerage" for most services, instead the Assertive Treatment team is most often the primary provider of services. Services, by necessity, are highly individualized and provided in the community, i.e., in the client's own neighborhood, at employment sites in the community, and in the same places most people spend their leisure time. Following the consumer's own self-directed priorities and timing for services, and respecting consumer autonomy, active assistance is provided by the team to assist consumers in accessing needed resources. The team nurtures consumer trust and develops a therapeutic working alliance.

Much discussion of late has centered around the belief by some advocacy groups that ACT (the model on which Assertive Treatment is based) does not allow for or promote consumer recovery from psychiatric illness. Pure ACT model programs are criticized for the invasiveness of their services and their strict adherence to the policy that once involved with an ACT team, consumers must always be involved with ACT. The Maricopa County RBHA is committed to the goal of recovery from psychiatric illness and is aware of the criticisms and concerns regarding the pure ACT model. For those reasons, the RBHA has

chosen to implement this modified version of ACT, which, among other things, allows for "graduation" to a lesser intensity of service.

The RBHA intends to initiate one Assertive Treatment Team as a demonstration project by April 30, 2001. It is anticipated that, given sufficient resources for full implementation throughout Maricopa County, Assertive Treatment teams will serve no more than approximately 10% of all consumers with serious mental illness.

2. ***Target Population***

Assertive Treatment services target the most significantly disabled consumers, or the consumers in greatest need. Typically, this group includes individuals with DSM-IV Diagnoses including schizophrenia, other psychotic disorders and bipolar disorder, that generally impair an individual's ability to function in areas such as daily living skills, decision making or employment. In addition, Assertive Treatment services may be appropriate for individuals (and others) who experience significant disability from other disorders, such as obsessive-compulsive disorder who have not been helped by traditional mental health treatment.

Consumers in greatest need include individuals who have severe symptoms and impairments not effectively remedied by available treatments or who, for reasons related to their mental illness, resist or avoid involvement with mental health services. Consumers in greatest need often have the poorest quality of life and claim the greatest social and financial costs of all those with serious mental illnesses, being more likely to frequently use emergency and inpatient medical and psychiatric services, to be homeless and live in substandard housing, to be arrested or incarcerated, or to die prematurely from suicide or physical illness. This also includes individuals who are ordered into treatment involuntarily.

3. Assertive Services

Relieving symptoms and minimizing the time consumers spend in psychiatric hospitals is extremely important to successful rehabilitation and recovery. Because symptoms are responsible for much of the distress and much of the functional impairment experienced by people with serious mental illness, treatment of symptoms must be a focus of any comprehensive system of care. Assertive Treatment includes such community-based interventions as:

Diagnosis, focusing on target symptoms and prodromal symptoms of relapse

Psychopharmacological Treatment, in which the team assumes primary responsibility for all medication prescribing, administration and distribution, including in-home services, intensive medication monitoring, and delivery of daily medication dosages

Supportive Counseling, provided by the team to address symptoms, stress, and interpersonal issues that occur in work and living situations, delivered in any number of community settings

Crisis Intervention by the team during regular work hours and by on-call staff at other times

Substance Abuse Treatment, primarily provided by Assertive Team staff (individual and group), including supportive and cognitive-behavioral treatment. Outside providers are used when inpatient services are needed to detoxify consumers, reduce heavy substance abuse or establish linkages to outpatient treatment. Self-help programs are also utilized

Rehabilitation Services, supporting individuals to participate in normal adult activities in the community, including structuring time, work-related services, independent living skills, social and interpersonal relationships, and use of leisure time

Support Services, including advocacy, coordination, side-by-side individualized support, problem solving, direct assistance, training and supervision to help consumers obtain medical and dental care, legal and

advocacy services, financial supports (including entitlements such as SSI and SSDI), supported housing, money management services and transportation

4. Role of Outside Providers/Stakeholders

Assertive Treatment differs from traditional case management in its intensity and staffing configuration. In the purest ACT model, the case management team delivers virtually all services. This effort involves the design and implementation of a modified program of ACT services that involves providers and stakeholders as members of the team. Some primary examples include:

Rehabilitation Services Administration (RSA)
RSA, Arizona's public Vocational Rehabilitation (VR) Program, will remain an integral part of rehabilitation services delivery in Maricopa County. The Rehabilitation Specialist on the Assertive Treatment team will develop and maintain a relationship with one RSA Counselor assigned to work with Assertive Treatment consumers. Regular meetings with the RSA Counselor and the Rehabilitation and Employment specialists will enhance communication between RSA and the team. It is anticipated that the Assertive Treatment team will secure an RSA contract to provide employment-related services, utilizing revenues generated to offset salary costs of vocational staff.

Substance Abuse Services
While the team provides most substance abuse services, they will selectively utilize outside treatment providers. Outside providers are enlisted when inpatient services are needed to detoxify consumers, induce remissions of heavy substance use, or establish linkages to outpatient treatment. Consumers are encouraged to utilize self-help programs, such as Alcoholics Anonymous (AA) and Narcotics Anonymous (NA), outpatient services and residential facilities, but only those that are adapted to consumers with dual diagnosis. The team Substance Abuse Specialist will provide the communication link to community-based substance abuse treatment providers.

Housing
Currently, Arizona Behavioral Health Corporation (ABC), the RBHA-contracted Housing Administrator, administers HUD-funded homeless housing grants, which include Shelter Plus Care and Supportive Housing programs. The RBHA administers state-funded housing programs (homeless and non-homeless), including ASH reduction, supervisory care, and other state funded housing programs for individuals with serious mental illness, as well as a Network of outpatient residential treatment programs, group homes, etc. Through the provision of support services, which includes support of daily living and stabilization and retention of housing, Assertive Team Staff (especially both the Housing Specialist and Independent Living Specialists) will provide the communication link to housing and residential providers through regular contact and interactions.

Other Providers
Prior to implementation a number of tasks will occur so that Network providers are included in the Assertive Treatment process. These include establishing a network alliance for collegial exchange, identifying collateral resources and services, establishing community alliances and establishing links with self-help entities and consumer-operated services.

5. Assertive Treatment Team Members

Assertive Treatment Team members share many roles and strive to function interchangeably to provide intense, continuous, and coordinated treatment, rehabilitation and support services each day to consumers. The multidisciplinary composition of the team ensures that sufficient numbers of specialists exist who have training, expertise and experience in each program area, so that the team can provide treatment, rehabilitation and support services, education and consultation to families, substance abuse services, and assessment and case-management services. All staff positions described below are involved in the provision or participate in the provision of the core program services described above.

However, levels of responsibility vary for each staff member by discipline and training and/or by specific program designation. For example, bachelors-level mental health workers cannot give an injection or handle medication because they are not licensed to do so, but they can carry out medication related tasks. The license and training required for the registered nurse position result in the nurses on the team having primary responsibility for psychopharmacologic and medication treatment, under the clinical supervision of the Prescriber. However, the whole staff participates in various medication administration activities i.e., medication delivery, medication education and assessment of response to medication, under the supervision of the psychiatrist and registered nurses and according to state laws for medication administration.

Below you will find a table summarizing team members with associated core functions.

Summary of Assertive Team Members and Primary Functions

The initial Assertive Treatment Team proposed for implementation in Maricopa County will include the following team members:

TEAM MEMBER	PRIMARY FUNCTION
Team Coordinator	Administrative supervisor, practicing clinician, will provide clinical supervision to non-medical staff
Psychiatrist	Supervises staff delivery of direct clinical services, monitors consumer's clinical status
Rehabilitation Specialist	Comprehensive assessment of meaningful community activity needs and desires, whether paid or unpaid, lead in service planning for rehabilitation and employment, interface with RSA programs and services when appropriate (services partially reimbursable by RSA)
Housing Specialist	Comprehensive assessment of housing, residential and ADL skills and needs, lead in service planning for ADL and housing support services
Substance Abuse Specialist	Provides and coordinates substance abuse assessments, treatment planning and service delivery tailored to individual needs of consumers with dual diagnosis disorders
Behavioral Health Tech(s)	Provides assertive treatment services, implementing plans for treatment, rehabilitation and support services
Employment Specialist (B. Mgt. Tech)	Situational assessment, job development and placement, supported employment, long-term employment supports (services are 100% reimbursable by RSA)
Independent Living Skills Specialist (B. Mgt. Tech)	ADL skills teaching, implementation of support services plans
Psychiatric Nurse(s)	Basic health and medical assessments and education, coordination of health care provided in the community, psychiatric medical assessment, treatment, psychotropic medication administration
Transportation Specialist	Transportation assistance for consumers in the community, mobility training, delivering food boxes and medications
Program Assistant	Organizing, coordinating and monitoring all non-clinical operations of the team, including medical records, MIS, accounting/budgeting, coordination communication.

B. Supportive Case Management Treatment

1. General Description

Supportive Treatment is delivered and coordinated by multi-disciplinary staff based in mental health centers in various locations throughout Maricopa County. Supportive services are generally available Monday through Friday, 8:00 a.m. to 5:00 p.m. It is a recovery-focused and outcome oriented model of community psychiatric treatment. Interventions are designed to foster learning and growing in a supportive community atmosphere, focusing on consumer strengths as the springboard for all service planning and delivery. After-hours crisis services are available by contacting RBHA Crisis Phone Clinicians, who coordinate, as needed, with on-call Supportive Treatment clinicians, as well as with other providers within the contracted Crisis Network.

Staff delivering Supportive Treatment include a Prescriber (psychiatrist, nurse practitioner or physician's assistant, under the supervision of an M.D.), Nurse, Team Coordinator and Behavioral Health Technicians. As defined by need, the consumer's individual team will include staff members possessing significant experience in substance abuse and housing issues, to act sufficiently as specialists for the team in their respective areas, as recommended by the Strategic Plans for Housing and Dual Diagnosis. Consistent with the recovery focus and emphasis on self-sufficiency through consumer involvement in meaningful community activities (whether paid or unpaid) established by the Strategic Plan for Vocational Rehabilitation, each team will also include an identified Rehabilitation Specialist. Rehabilitation Specialists will assist consumers to achieve active and consistent engagement, assessment of consumer rehabilitation needs and access to appropriate community rehabilitation services. A more complete team description appears in following sections.

While the Assertive Treatment model focuses heavily upon the delivery of services by the clinical team in the community, with staff available 24 hours each day, Supportive Treatment focuses upon maximizing community resources and coordination of care. Multi-disciplinary treatment teams in this service category include Network Providers, State agencies and others as members of the clinical team, heavily involving such stakeholders in the service planning and delivery process.

The RBHA intends to initiate a demonstration project involving the establishment of four Supportive Treatment Teams (as described in the Implementation Plan) by December 1, 2000. It is anticipated that, given additional resources for full implementation, Supportive Treatment Teams would serve approximately 80% of consumers with serious mental illness in Maricopa County.

2. Target Population

Supportive Treatment focuses upon adult consumers exhibiting severe to moderate functional impairment as a result of serious mental illness for whom less intensive case management will not likely result in the exacerbation of problems. Such individuals require assistance, support, guidance and monitoring in order to maximize benefit from services. Typically, Supportive Treatment is for individuals who are:

- Actively pursuing recovery goals
- Experiencing increased stability
- Able to express clear preferences about the direction of their lives, especially in relation to work or living situations
- Beginning growth and development activities
- In need of specialized interventions and/or training in specific skills

Such consumers require specific rehabilitative treatment in those areas affected by their psychiatric disability, including daily living skills, communication, attention and concentration, interpersonal relationships, understanding the use of psychotropic medications, symptom management, vocational performance, etc. The emphasis of this modality is on the acquisition of skills, supports and resources, which will support a focus on assisting consumers in meeting their own goals.

3. Supportive Treatment Services

Supportive services focus upon assisting consumers to achieve recovery and foster role functioning. Supportive Services are provided in the most appropriate setting, both office-based and in the community. They include:

Diagnosis, focusing on target symptoms and prodromal symptoms of relapse

Psychopharmacological Treatment, including a strong educational component ensuring consumers are educated regarding the implications of psychopharmacological services on recovery, symptom and side-effect management, etc.

Supportive Counseling, whether provided by team staff or through Network Providers, focusing on obtaining the information and skills necessary to achieve recovery goals and improve functioning

Assessment, Evaluation and Treatment Service Planning, including the process of assisting the consumer in identifying and prioritizing areas of need, desire and motivation to address

Coordination of Care, including linkage to treatment services available in the community, through the Network of Providers, State or local agencies, or other such community services, including health care and substance abuse providers.

Rehabilitation, a primary focus of Supportive Treatment, assisting consumers to develop greater competencies in meaningful community activities, employment, activities of daily living, social performance, and increase overall independence and self-management. Rehabilitation services include those provided directly by team staff or by Network Providers or other agencies.

Support Services, including advocacy, coordination, individualized support, problem solving, direct assistance, training, information and education to help consumers obtain medical and dental care, legal and advocacy services, financial supports (including entitlements such as SSI and SSDI), supported housing, money management services and transportation.

4. Supportive Treatment Team Members

Similar to Assertive Treatment Team members, Supportive teams must possess a wide range of aptitudes and professional skills. As the overall goal of Supportive Treatment is fostering consumer recovery from mental illness, all team members must have an excellent understanding of recovery and best practices in psychiatric rehabilitation.

The optimal team requires the presence of staff members with sufficient individual competence to establish the quality of clinical supportive relationships consumers require for effective identification of areas of desire or need. Fostering recovery implies significant attention to informed choice. Team staff must devote time and energies toward consumer education regarding the implications of serous mental illness, managing symptomology and involvement in meaningful community activities.

Supportive Treatment Team members share some roles and strive to provide rehabilitation and recovery-focused services. The multi-disciplinary composition of the team ensures that sufficient numbers of staff are available who have training, expertise and experience in each service area so that the team can effectively plan and deliver services.

Staff must be flexible, versatile and able to work both independently and collaboratively in the community. Significant strengths must be demonstrated in the areas of assessment, evaluation and service planning. The collaborative nature of Supportive Treatment requires significant involvement of outside stakeholders, such as Network Providers and State Agencies, necessitating a high degree of skill, knowledge and experience in the utilization of community resources. Further, staff must possess excellent customer service skills, being able to work collaboratively and cooperatively with professionals (and others) in the community. Specifically, teams demonstrate the following characteristics:

- A mix of individuals with clinical and rehabilitation training and experience as well as the ability to establish caring, trusting relationships based on respect for individual consumers
- A percentage of staff with professional degrees in mental health professions
- A Team Coordinator and a prescriber working as practicing clinicians on the team
- Staff members with training, experience and knowledge sufficient to act as clinical team experts in the areas of Substance Abuse and Housing
- A qualified Rehabilitation Specialist.

Due to the specialized nature of assessment and service planning surrounding substance abuse and housing or residential issues, it is necessary for members of the Supportive Team to be designated as Substance Abuse and/or Housing Specialists. This designation is an additional responsibility carried by one or more existing team members (Team Coordinator, RN, Psychiatrist, Behavioral Health Technician). The Substance Abuse Specialist must possess significant education and/or experience in the delivery of substance abuse services (as outlined in the Core Competencies) and will serve as the team expert in assessment and planning of substance abuse treatment. This individual may maintain a caseload assignment of consumers with significant substance abuse issues.

The Housing Specialist must possess significant experience in the assessment of housing, residential and independent living needs and thorough knowledge of community resources, housing and residential programs. This individual will serve as the team expert in assessing and planning for housing services. This individual may maintain a caseload of consumers with significant or difficult independent living issues.

Individuals may be hired on as "experts" with continued training provided, or existing personnel may be trained to the required level of expertise. Ongoing competency testing will assure that individuals fulfilling these responsibilities meet minimum knowledge requirements. The Substance Abuse and Housing Specialists will:

- Act as consultants to the team regarding individuals experiencing difficulties with either or both areas
- Participate in staffings to discuss complex cases
- Provide resource information to the team
- Provide hands-on interventions with the individual
- Complete assessments for substance use/abuse, independent living skills, etc., in order to determine treatment/service needs.

The following table summarizes core team members for Supportive Treatment Teams.

TEAM MEMBER	PRIMARY FUNCTION
Team Coordinator*	Leader of the individual treatment team, coordinator of care
Prescriber*	Supervises staff delivery of direct clinical services, monitors consumer's clinical status
Psychiatric Nurse*	Basic health and medical assessments and education, coordination of health care, psychiatric medical assessment, treatment, psychotropic medication administration
Behavioral Health Technicians*	Provide supportive treatment services, implementing plans for treatment, rehabilitation and support services and coordinating services with Providers, State Agencies, etc.
Rehabilitation Specialist	Comprehensive assessment of rehabilitation needs, lead in service planning for rehabilitation services, interface with vocational programs/services (when appropriate)
Stakeholders	Network Providers, State Agencies (such as RSA, DDD, etc.) participate in the service planning process, providing specialized services (such as Supported Employment) to consumers

* One of these individuals will be designated as Substance Abuse Specialist and/or Housing Specialist.

C. Connective Case Management Treatment

1. Service Description

Connective Treatment serves those consumers who have largely achieved recovery and are concerned with maintaining their level of functioning and who are able to manage their illness with moderate levels of supportive counseling and guidance and independently seek outpatient services. As this service is available to adults with minimal functional impairment, Connective Treatment focuses primarily on psychopharmacological services, careful monitoring and linkage to service. Services are available Monday through Friday, 8 a.m. to 5 p.m. in mental health clinics throughout Maricopa County. Crisis services are available 24 hours/7 days a week through the RBHA Crisis System.

The consumer's Connective Treatment Team serves as a single point of contact within the mental health system. Psychopharmacological services are provided, with consumers typically making monthly (but at least quarterly) visits to the clinic for medication management. The Prescriber assists the consumer in identifying needed services. As needed, Behavioral Health Technicians provide a connection to the Network of providers, State agencies or other such community services. Crisis service utilization is typically minimal.

Connective Teams include a Team Coordinator, Prescriber (Psychiatrist, Nurse Practitioner or Physician's Assistant under the supervision of a Psychiatrist), Nurse and Behavioral Health Technician (only as needed). No identified Team Specialists (such as Substance Abuse or Housing Specialists) are included on the team. However, consultation with qualified specialists is available when necessary. Rehabilitation services are provided by an assigned VR Counselor employed by RSA.

2. Target Population

As stated above, consumers served by Connective Teams have made significant progress in recovery. Their illness is well controlled and they are primarily focused upon maintaining current functioning level. Such individuals actively seek assistance, contacting team members when there are problems with mental health services, when access to community resources is needed, or when they (or their family members) feel that the symptoms and problems associated with their illness is increasing. They rarely require inpatient or crisis services. Consumers involved with Connective Teams may also have ongoing supports in significant life areas.

Because consumers who receive this intensity of service have moderate functional impairment due to their mental illness, the focus is on empowerment to independently meet their own needs. Their team serves as a mental health system resource. Specifically, Connective Treatment consumers have:

- Largely achieved recovery goals, functioning adequately in key social roles, especially in relation to work or living situations
- Achieved stability
- Capacity to actively express clear preferences about the direction of their lives and seek out necessary community support services.

3. Connective Treatment Services

Diagnosis, focusing on target symptoms and prodromal symptoms of relapse.

Psychopharmacological Treatment, the primary service provided by Connective Treatment Teams.

Supportive Counseling, available through Network Providers.

Assessment, Evaluation and Treatment Service Planning, includes the process of assisting the consumer in identifying and prioritizing areas of need, desire and motivation to address. At this level, individuals develop a treatment plan based primarily on the services they are receiving from the Prescriber. This plan is developed by the individual and the Prescriber to include prescribed medication, required labs or other nursing intervention.

Coordination of Care provided by a Behavioral Health Technician on an "as needed" basis, involves linkage to treatment services available in the community, through the Network of Providers, State or local agencies, or other such community services, including health care and substance abuse providers.

Rehabilitation, including consultation regarding rehabilitation and employment services, is available on an as needed basis through VR Counselors employed by RSA, assigned to work with Connective Treatment Teams.

Support Services linkages are available on an as needed basis through Behavioral Health Technicians.

4. Connective Treatment Team Members

Connective Treatment Teams differ significantly from Assertive or Supportive Teams in that they are smaller and members largely work independently, focusing upon assisting the consumer to maintain recovery gains. An understanding of recovery and the ability to monitor for changes in a consumer's functioning level is crucial. The connective nature of these teams requires significant involvement of outside stakeholders, such as Network Providers and State Agencies, necessitating a high degree of skill, knowledge and experience in the utilization of community resources and excellent coordination and organizational skills.

The following table provides a summary of core team members for Connective Treatment Teams.

TEAM MANAGER	FUNCTION
Team Coordinator	Administrative supervisor, coordinator of care and provides clinical supervision to non-medical staff
Prescriber	Supervises staff delivery of direct clinical services, monitors consumer's clinical status
Psychiatric Nurse	Basic health and medical assessments, coordination of health care, psychiatric medical assessment, psychotropic medication administration
Behavioral Health Technicians	As needed, provides linkages to community-based mental health or rehabilitation services, coordinates services with Providers, State agencies, etc.

D. Treatment Team Comparison

	ASSERTIVE	SUPPORTIVE	CONNECTIVE
Description	• Modified ACT Model • Mobile Treatment Team • Provides most services directly, "in vivo" • 24 hours per day, 7 days per week	• Multi-disciplinary Treatment Team • Goal directed, recovery focused • Community-focused coordination of care • Significant inclusion of Providers/State Agencies • Mon – Fri, 8 - 5	• Small, Clinic-based Treatment Team • Psychopharmacological Treatment, monitoring and service linkages • Mon – Fri, 8 - 5
Target Population	• Consumers in greatest need with severe functional impairment • Require intensive support and intervention to remain in the community • Less than 10% of total consumers with serious mental illness	• Consumers with severe to moderate functional impairment • Require assistance and support to achieve goal of recovery • Approximately 80% of total consumers with serious mental illness	• Consumers with moderate functional impairment • Require outpatient services to maintain recovery • Approximately 10% of total consumers with serious mental illness
Focus	• Functional Stabilization	• Rehabilitation	• Maintenance of Recovery Goals
Goals	• Decreasing debilitating symptoms/side effects • Increasing periods of independence • Minimizing periods of crisis/severe dysfunction • Establishing sense of self and personal aspiration	• Choosing and pursuing rehabilitation and recovery goals • Recovering functioning in multiple life areas	• Maintaining stability and independence • Prescribing • Single point of contact for linkage to mental health services
Admission Criteria	Please see page 36	Please see pages 40 - 41	Please see page 44

	ASSERTIVE	SUPPORTIVE	CONNECTIVE
Team Composition	• Prescriber (Psychiatrist) • Team Coordinator • Psychiatric Nurse(s) • Rehabilitation Specialist • Housing Specialist • Substance Abuse Specialist • Behavioral Health Techs • Paraprofessional Mental Health Workers: ▪ Employment Spec. ▪ IL Specialist ▪ Transportation Spec. ▪ Peer Support Worker • Program Assistant	• Prescriber* (Psychiatrist, Nurse Practitioner, PA, under Psychiatrist supervision) • Team Coordinator* • Psychiatric Nurse* • Rehabilitation Specialist • Behavioral Health Techs* • Stakeholders/Providers * at least one team member will possess skill or experience sufficient to be identified as a SA or Housing Specialist)	• Prescriber (Psychiatrist, Nurse Practitioner, PA under Psychiatrist supervision) • Psychiatric Nurse • Behavioral Health Tech (only as needed)
Clinical Authority	• Prescriber provides medical supervision • Team Coordinator provides clinical and administrative supervision for non-medical staff • Entire clinical team has authority for clinical decisions	• Prescriber provides medical supervision • Lead Clinician provides clinical and administrative supervision for non-medical staff • Entire clinical team has authority for clinical decisions	• Prescriber provides medical and clinical supervision for the team • Lead Clinician provides clinical and administrative supervision, if services other than medical are required
Individual Caseload Size	12	30	70
Caseload Size (per Prescriber)	80 - 120	200 - 250	350
24-hour Availability	Coordinated by Team	On-call after-hours; Crisis managed by Network	Low need for Crisis Services—managed by Network
Stakeholder Role	Most services provided by Team	Significant inclusion of Network Providers and State Agencies as members of the Team	Linkage and referral to Network Providers, State Agencies or other community services as appropriate

This concludes Section 4-1, Three Service and Resource Intensities. Section 4-2 below will discuss how consumers are assigned to these three levels.

4-2. CONSUMER ASSIGNMENT TO SERVICE LEVEL

Consumer assignment to service level is based on both clinical need and consumer preference. On the following pages you will find a flow chart outlining the process for identifying consumer service level and the criteria for assignment to service intensity level.

These are draft criteria that will be further refined during the implementation phase.

A. Process for Identifying Service Intensity of Case Management

Initial Intake and Evaluation

Evaluator (Masters Level certified clinician) assesses consumer status and makes recommendations for specific assessments to be completed at the team level

↓

Consumer assigned to local site based on ease of access (with the exception of ASH Transition Site)

↓

Local Site assigns Team Coordinator, who schedules consumer for recommended and/or required evaluations

↓

Comprehensive Assessment

Assessments are completed by specialists within the site and forwarded to the Prescriber

↓

Prescriber reviews all evaluations and completes Psychiatric Evaluation

↓

Team Coordinator Completes the Assessment Summary

↓

Based on Team Coordinator's recommendation and consumer preference, consumer is assigned to service intensity level

Team Coordinator utilizes information from evaluation, assessment and criteria for Case Management Service Intensity Level, which includes consumer preference in formulating recommendation. See the following page for Case Management Service Intensity Level criteria.

B. Case Management Service Intensity Criteria

ASSERTIVE	SUPPORTIVE	CONNECTIVE
Qualifying SMI DSM IV Dx, severe functional impairment, and at least one of the following:* a. significant functioning impairments, including inability to consistently perform practical daily living tasks for basic adult functioning in the community; inability to be consistently employed at a self-sustaining level or inability to consistently carry out homemaker roles; and, inability to maintain a safe living situation; b. one or more indicators of continuous high-service needs (greater than eight hours per month), including high use of psychiatric hospitals or emergency services; persistent or very recurrent major symptoms; high risk or recent criminal justice involvement; inability to meet basic survival needs or residing in substandard housing; homeless, or at risk; residing in inpatient bed or supervised community residence, but clinically assessed to be able to live in a more independent situation if intensive services are provided, or requiring a residential institutional placement if more intensive services are not available; and, inability to participate in traditional, office-based services.	Qualifying SMI DSM IV Dx, severe or moderate functional impairment, and at least one of the following: a. more intensive services may be needed but have been rejected despite many attempts at persuasion and/or outreach; b. a history of hospitalizations but no recent crisis episodes; c. significant difficulty in managing extended periods, i.e., six months or more of recovery without additional supports and professional care.	Qualifying SMI DSM IV Dx, moderate functional impairment, and at least one of the following: a. more intensive services may be needed but have been rejected, despite many attempts at persuasion and or outreach; b. an extended period with no hospitalization; c. documented extended stability with no major crisis episodes; d. documented ability to manage illness and life with minimal assistance; e. largely self-manage disability and medications.

* Priority is given to people with schizophrenia, other psychotic disorders and bipolar disorder. PACT model studies indicate individuals with a primary diagnosis of Mental Retardation, Substance Abuse or Borderline Personality Disorder do not typically benefit from this type of intensive service. Over time, specialized Assertive Teams may be created for these populations.

It is important to note that the above criteria will be refined and revised through succeeding planning and implementation activities surrounding the design of Intensive Case Management teams and is by no means meant to represent final selection criteria.

4-3. CHANGES IN INTENSITIES OF SERVICE

Recognizing the cyclical nature of psychiatric disability and the changing needs of consumers, a primary focus of this plan is to ensure that resources move with the consumer. Recovery from mental illness is an individual and personal process, and systems designed to foster recovery must be flexible, accommodating individual recovery needs.

A. Transition from Assertive to Supportive Treatment

While it is the intent of this plan to ensure resources follow the consumer and limit the need for consumers to change teams, transition from the Assertive Treatment Team will ultimately be necessary for many consumers and will require changes in staff. Assertive Treatment, the most intensive level of service, is provided by a self-contained team of staff with very specialized functions. Assertive Team Staff have been specifically trained for this purpose and provide the bulk of services in the community. Consumers served by the Assertive Treatment Team often develop very intense and close relationships with team staff.

As consumers achieve stabilization, build functional skills and begin working toward recovery, the team must begin planning for transition to Supportive Treatment. This point represents a tremendously significant milestone in the life of consumers and will occur over a six-month period. It is initiated after the consumer has achieved and maintained stability for a documented period of no less than two years. The Assertive Team will work with the consumer to create a detailed, step-by-step "Graduation" Plan, which will focus on maintaining gains and achievements and provide a structured process of increasing the involvement of new team members while decreasing the involvement of Assertive Team members.

Monitoring consumer progress toward recovery is an ongoing continuous process. As relapses occur, resources are immediately increased, whether in terms of adding specialists or other members to the treatment team or seeking additional, more intensive community services. Milestones in recovery may represent the need to decrease the intensity of resources, allowing consumers increasing opportunities to practice acquired skills and manage their own illness.

B. Transition from Supportive to Connective Treatment

The primary goal of Supportive Treatment is to identify and achieve recovery goals. When the team identifies that a consumer has largely achieved and maintained recovery for a period of no less than twelve consecutive months without the need for hospitalization or any significant disruption in daily functioning, the consumer will be considered for movement to Connective Treatment. As with Assertive Treatment, a "Graduation" Plan will be developed, which will focus on maintaining gains and achievements while ensuring a smooth process of decreasing the involvement of Supportive Team specialists, as well as a decreasing role for the Behavioral Health Technician, who will be available on an as-needed basis.

C. Transition from Connective to Supportive

When an individual experiences a relapse in symptoms of their mental illness that negatively effect daily functioning, and the individual does not reconstitute to baseline within two weeks, a transition to a Supportive Level is completed immediately. In this case, should the person reconstitute to prior level of functioning, a transition back to Connective Treatment can occur within 30 days.

On the following pages you will find working guidelines for increasing or decreasing service level intensity. Criteria for transition to the next level of service and the development of graduation plans will be further refined through plan implementation activities.

D. Resource Movement from Assertive Treatment

ASSERTIVE TREATMENT

Staff Resources

- Team Coordinator
- Prescriber
- Psychiatric Nurse
- Rehabilitation Specialist
- Employment Specialist
- Housing Specialist
- IL Specialist
- Paraprofessional
- Transportation Coordinator
- Peer Support

Primary Features

- Most intensive services
- Mobile Treatment Team
- Most services delivered directly by the team, with some Network Provider involvement

Increase in Intensity to Assertive Treatment

What Changes

Increased contact, such as multiple daily contacts, from Assertive Team Members and/or

Consideration of higher levels of care (i.e. partial, residential, inpatient) with team following consumer intensely in service environment

Criteria for Change

Consumer is not stable with daily Assertive Treatment Team contacts and intervention

Decrease in Intensity to Supportive Treatment

What Changes

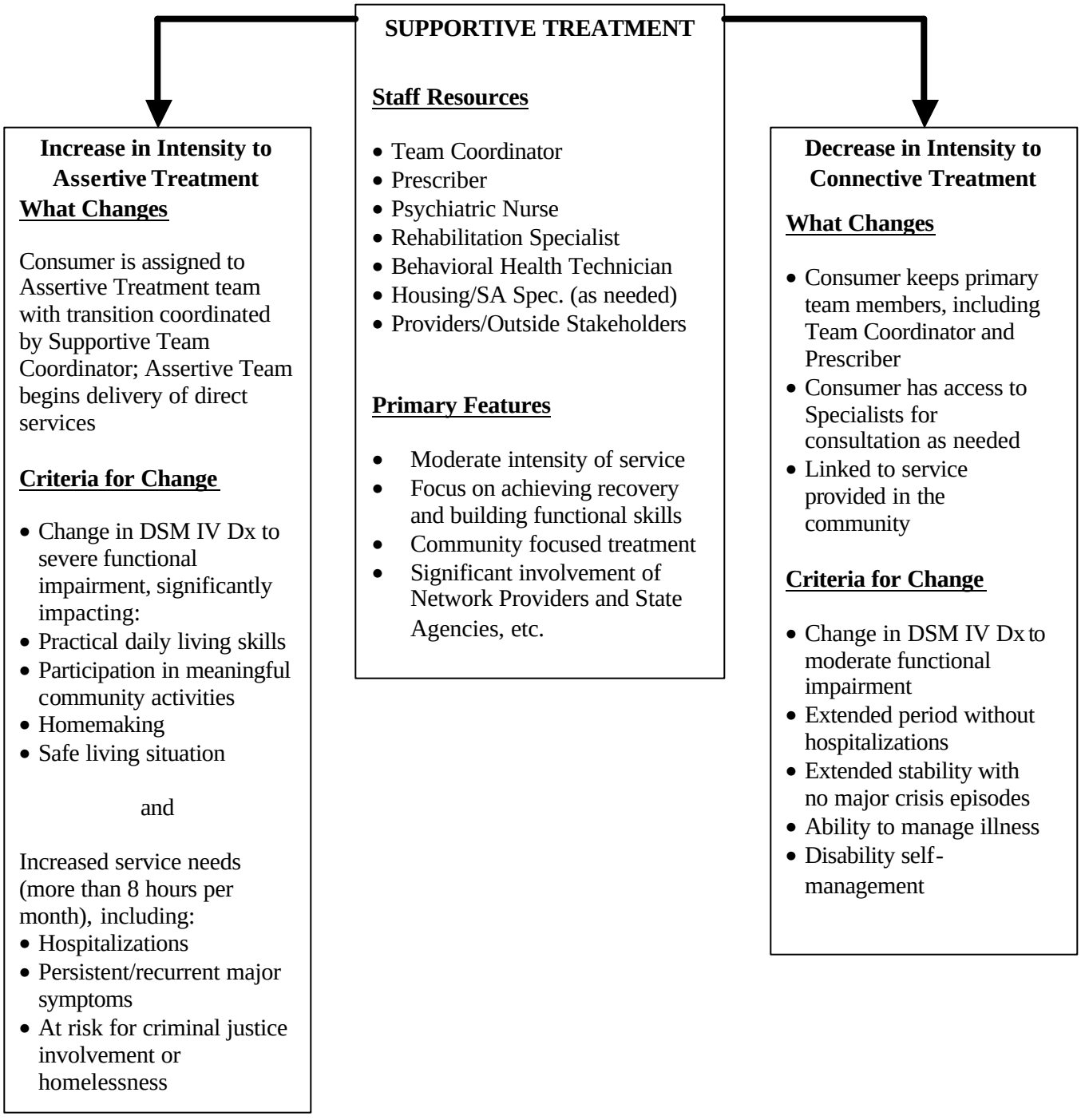
Due to the self-contained nature of Assertive Treatment, changes in staff are required.

Consumers making progressive moves to Supportive Treatment must be provided over a six month transition period, ensuring close coordination between team members and allowing opportunity for consumers to develop appropriate relationships with new team members and community service providers.

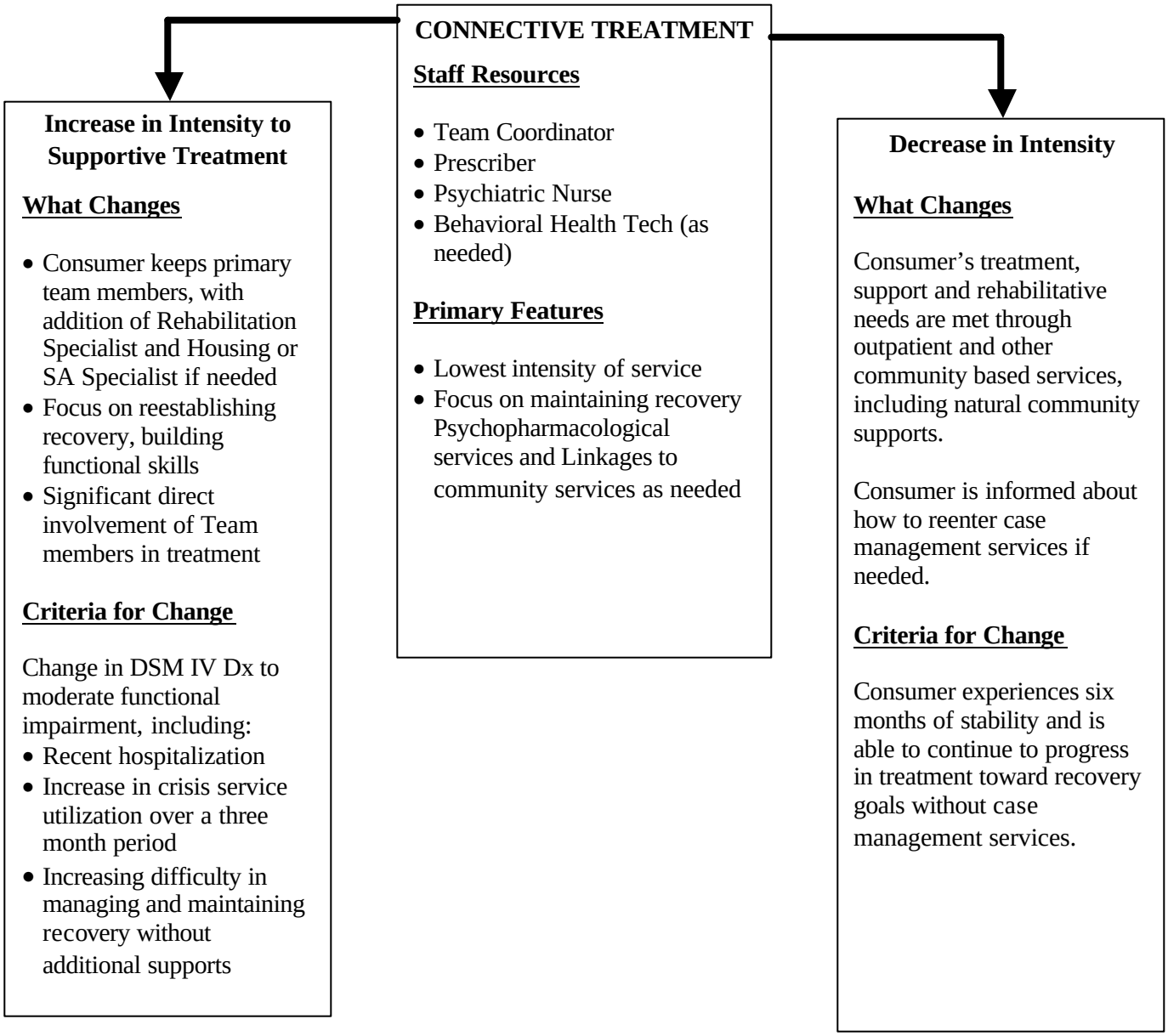
Criteria for Change

- Consumer must be stable for a period no less than two years
- History of hospitalization but no recent crisis episodes
- Six months or more in recovery without additional supports or professional care

E. Resource Movement from Supportive Treatment



F. Resource Movement from Connective Treatment



G. Monitoring for Appropriate Transitions between Intensities of Service

A quarterly audit will be conducted on a random sample of cases so that the assigned intensity of case management treatment is appropriate. Appropriateness of intensity will be tracked and trended to identify outliers in order to provide site-specific training. The scope of subsequent audits will be increased or decreased based on the performance on the prior audit.

4-4. Implementation of the plan

This section provides a brief overview of the RBHA's strategy to introduce these three service and resource intensities within Maricopa County.

A. Coordination with other Strategic Plans

The following section provides an overview of the Maricopa County RBHA's plan to operationalize enhanced clinical team services, in conjunction with the Strategic Plans for Rehabilitation, Housing and Dual Diagnosis.

a. Vocational rehabilitation

The Maricopa County Strategic Plan for Vocational Rehabilitation included a provision for the establishment of clinical teams based upon ACT models including Rehabilitation and Employment, Housing and Independent Living Specialists, as well as Peer Case Managers.

The Clinical Case Management Plan maintains consistency with the intent of the vocational strategic plan in intended team design, staffing configuration, services and relationship to RSA. Furthermore, this plan seeks to establish teams providing services at a much higher level of intensity than those described in the Vocational Plan.

b. Dual diagnosis

The plan to implement enhanced clinical teams, as described in this document, is consistent with the Proposed Treatment Model described in the Strategic Plan for Dual Diagnosis. Assertive and Supportive Treatment Teams will include one staff member qualified as a Substance Abuse Specialist who will possess significant education and specific experience in working with dually diagnosed individuals. Further, these Team concepts contain the same key features, including simultaneous treatment of both disorders by the same team, integrated treatment, psychopharmacological interventions, and Assertive case management.

c. Housing

The Strategic Plan for Housing states that: "Services shall be flexible so that support and supervision may be initiated, discontinued, increased or decreased as the class member's needs change so that the class member is not required to move to another setting as his or her needs change". Assertive and Supportive Treatment Teams, by design, offer the supportive services to consumers, especially in their own homes. The inclusion of Housing and Independent Living Specialists will provide adequate and appropriate assessment of consumer housing and daily living needs, service planning and intensive housing supports so that safe and secure housing is obtained and maintained. Team staff maintain close working relationships and communication with the Housing Administrator, providers and landlords.

RBHA managers from each of these areas, working toward implementation of the strategic plans, will figure prominently in the development and refinement of this implementation plan. This will provide continued attention to and coordination with Court-approved Strategic Plan requirements and tasks.

B. Implementation Approach

The RBHA intends to proceed with implementation methodically and incrementally, with great attention to detail, for the most successful implementation possible. This methodical approach is designed to:

- Prevent massive disruption within the service delivery system
- Allow for maximum team staff training, technical assistance, supervision and ongoing supports
- Assure implementation flexibility, providing opportunities to make adjustments or revisions in the structure and function of clinical teams
- Allow the most effective utilization of limited dollars through incremental funding
- Allow for thorough data collection, rapid analysis and prompt adjustments as necessary

The following gives a broad overview of the approaches for Assertive and Supportive and Connective implementations.

Phase I: Demonstration

1. Supportive Treatment Demonstration

By December 1, 2000, the Maricopa County RBHA will implement a Demonstration Project, utilizing existing resources, that will create four Supportive Treatment Teams in Maricopa County as described earlier in this document.

The overall goal of the Case Management and Clinical Team Services plan is to establish clinical teams that operate according to criteria for fully functioning clinical teams. This Demonstration Project offers the opportunity to reach beyond this overall goal, operationalize the RBHA's commitment to fostering consumer recovery from psychiatric illness and establishing a framework for true service integration within the mental health system. This ambitious project will significantly impact consumer transition from ASH to the community, enrich the services offered by residential and community rehabilitation providers, and incorporate integrated treatment criteria for individuals with co-occurring disorders.

Primary Features of the Supportive Treatment Demonstration Project will include:

- Contracting with national experts in psychiatric rehabilitation to assist in the planning and development of this demonstration, as well as in the development of intensive psychosocial rehabilitation training. This intensive training will include clinical team staff, residential and rehabilitation provider staff, and others who are involved in these demonstration teams.
- Providing ongoing and consistent technical support, assistance and mentoring to staff involved in the Demonstration project, including Clinical Team staff and team specialists, residential and rehabilitation providers and VR Counselors.
- Including RBHA Rehabilitation Specialists on each team and the development of a new agreement and relationship with RSA for access to VR Program Services. Rehabilitation Specialists will serve as the primary point of contact for VR Counselors involved with Demonstration Teams. Specialized training will be provided to both Rehabilitation Specialists and VR Counselors.
- Identification of a Substance Abuse and Housing Specialist for each team, who will function as the team expert in these areas. Specialized training will be provided to staff identified as specialists.
- Incorporation of Integrated Treatment Criteria developed by the ADHS Integrated Treatment Consensus Panel for the treatment of co-occurring disorders.
- Involvement of both Residential and Rehabilitation providers in the demonstration project, assisting providers in staff and program development, as well as developing new and different means of contracting and utilizing their services.
- Including a research component, heavily focusing on Utilization and Quality Management. One primary focus of these activities will include measures to examine consumer progress toward recovery goals over time.

- Implementation of Self-Directed Rehabilitation (SDR), Double Trouble and other recovery and empowerment related activities for consumers, both in the sites as well as in provider facilities, residential programs, etc., designed to create Recovery Communities.

As additional resources become available, this project will be expanded to include additional Supportive Treatment Teams in Maricopa County.

2. Connective Treatment Demonstration

By February 1, 2001, the Maricopa County RBHA will implement a Demonstration Project, utilizing existing resources, that will offer Connective Treatment services in one Maricopa County case management site, as outlined earlier in this document.

In addition to Recovery and Psychosocial Rehabilitation training provided by mentioned experts, ongoing technical support, assistance and mentoring for staff, and modifications to the ISP and Assessment as described above, the primary features of this project will include:

- Identification of consumers willing to participate in Connective Treatment, based on Admission Criteria described earlier in this document, as well as Prescriber hours required.
- Specialized training for Prescribers, Nurses and Behavioral Health Technicians involved in delivery of Connective Treatment services, including protocols for Connective Treatment assessment and treatment planning (with a primary focus on early identification of prodromal symptoms of relapse in order to promote continued recovery), community resources and recovery monitoring.

3. Assertive Treatment Demonstration

By April 30, 2001, the Maricopa County RBHA will implement a Demonstration Project, utilizing existing resources, that will create one Assertive Treatment Team in Maricopa County, as described earlier in this document.

The intention of this plan is to initially implement an Assertive Treatment Team with existing resources and to expand the number of teams as resources become available

Each team, once initiated, will be continuously evaluated for a period of six months. This evaluation process will ensure the project maintains fidelity to each model of service delivery, follows best practices of psychiatric rehabilitation and functioning criteria for clinical teams. More importantly, however, this evaluation process will be utilized to rapidly make any adjustments or changes to the clinical team model.

To deliver the type and intensity of services necessary to get positive clinical outcomes for consumers, sufficient numbers of personnel and a rich staff-to-consumer ratio are essential. Assertive Treatment Team staff size will be no more than twelve full-time-equivalent clinical and rehabilitation positions, plus a program assistant and a half-time psychiatrist. The careful selection of individuals to participate as initial team members will be key to the success or failure of this effort. Staff selected for each initial team will receive intensive, targeted training prior to start-up, as well as intensive technical support, assistance and supervision following initiation. These staff will then become the corps of experts, providing training to staff selected for succeeding teams, should additional resources become available.

The Assertive Treatment Team will operate with a staff-to-consumer ratio of approximately 10 consumers per staff person. It is anticipated that the Assertive Team involved in this demonstration will serve no more than 80 consumers initially (not to exceed 120). Over the evaluation period, however, the team will be involved in the process of building, admitting consumers over a period of time, rather than attempting

to serve 80 consumers on the start date. By allowing this process of building, team staff will be better able to build the capacity to effectively deliver Assertive Team services and to develop the necessary intensive relationships with consumers.

Phase II: Evaluation

The structure and operation of each team described above will be evaluated for a period of no less than six months. This evaluation period is necessary to ensure rapid changes and adjustments to site configurations, staffing patterns, etc., are made prior to the implementation of additional teams.

Phase III: Expansion

Each of the demonstration teams described above will be implemented utilizing existing RBHA resources. Both Supportive and Assertive Treatment require significant resources in terms of additional staff costs to achieve the required number and mix of team specialists. Additionally, Assertive Treatment requires significant capital investment in terms of facilities and infrastructure.

For these reasons, the RBHA will focus first upon the expansion of Connective Treatment Teams, which are not resource dependent. Additional Supportive Teams will be implemented as cost savings are incurred through implementation of Connective Treatment Teams, and/or additional resources become available through legislative or other budget action.

The next section, *Workp**lan for Implementation*** provides initial target dates for major tasks related to implementation.

IV. WORKPLAN FOR IMPLEMENTATION

Implementation of the plan for enhanced clinical teams will be phased in throughout the system in an orderly, progressive fashion. This implementation plan will be sensitive to consumer needs and established relationships and will be designed to cause as little disruption for consumers, providers and other stakeholders as possible.

Preliminary input has already been gathered from staff, consumers and stakeholders regarding this plan. A Design Operation Team, facilitated by a Program Administrator, has also been established with members chosen from clinical services, psychiatry and medical services, rehabilitation services, quality management and training. Additional personnel will be included from other departments, e.g. housing, substance abuse and finance, as needed for specific tasks.

The Design Operations Team is charged with the primary task of finalizing and refining overall implementation plans and strategies surrounding enhanced case management. This group will ensure coordination with the strategic plans for housing, dual diagnosis and rehabilitation.

The following presents a description of focus areas for the implementation of initial enhancements.

Objective One

Enhance both the individual and team competency level of all staff providing case management and clinical team services for adults with serious mental illness in Maricopa County, including the following strategies:

Task	Responsibility	Target
Performance Improvement Plan/Staff Competency Phase I (as described on pages 19 and 20)	Training, Regulatory & Compliance	April, 2000 to April 2001
Initiate Monthly "Team Score Cards" (as described on pages 27 and 28)	Training, Regulatory & Compliance, QM, Clinical Services, Site Administrators	June 1, 2000
Complete the "Clinical Team Resources Manual", a comprehensive guide to enhanced clinical team services in Maricopa County, including finalized job descriptions, Policies and Procedures, service definitions, practice guidelines, and other required information	Design Operations team	September 30, 2000
Deliver Recovery and Rehabilitation Training Modules (as described on pages 25 and 26)	Service Integration	September 2000 to September 2001
Initiate Recovery and Wellness Education and Information activities	Service Integration	December 31, 2000
Performance Improvement Plan /Staff Competency Phase II: (as described on pages 20)	Training, Regulatory & Compliance	May 2001 to April 2002

Objective Two

Increase the level of involvement and participation by external clinical team members (i.e., providers, state agency representatives, etc.), in accordance with AAC R9-21-101(10).

Task	Responsibility	Target
Establish an "Enhanced Clinical Services Advisory Panel", including key community stakeholders such as consumers, community advocates, representatives from Network Providers and State Agencies, etc. The Advisory Panel will develop community linkages, identify strategies to bridge resource gaps and reduce system-wide barriers, enhance communication and foster inclusion of stakeholders as members of clinical teams	VP Program Management	July 31, 2000 Ongoing
Review RBHA policies and procedures, and Program Service Guidelines for providers regarding inclusion and participation of stakeholders in the coordination of care process	Enhanced Clinical Services Advisory Panel	September 30, 2000
Hold public "kick-off" forums targeting consumers, family members, providers, stakeholders and staff, designed to provide information regarding implementation plans and intended changes in the system over the next two years	Design Operations Team	September 30, 2000

Objective Three

Enhance the assessment and individual service planning process, including the following strategies:

Task	Responsibility	Target
Review and revise the current assessment process, including associated procedures, tools and forms, delineating staff roles and responsibilities	Design Operations Team	September 30, 2000
Modify the current ISP to simplify the planning process, accommodate system enhancements, foster recovery, and include a Rehabilitation/Career Plan as part of each consumer's ISP (as required by the Strategic Plan for Employment and Rehabilitation)	Design Operations team	September 30, 2000

Objective Four

Implement a clinical team demonstration project, designed to evaluate and establish a new structural model and configuration for clinical teams in Maricopa County, employing the following strategies:

Task	Responsibility	Target
Identify all legal and/or risk management issues surrounding implementation of Demonstration Projects, including a review of malpractice insurance coverage and liability issues	Design Operations Team	September 30, 2000
Identify site configuration and infrastructure requirements for initial Supportive Demonstration site	Design Operations Team	September 30, 2000
Implement plan for four Supportive Treatment Demonstration sites (as described on pages 40 to 43)	Design Operations Team	December 1, 2000
Identify site configuration and infrastructure requirements for initial Connective Demonstration Site	Design Operations Team	December 31, 2000
Identify consumers (system-wide) meeting criteria for connective treatment; select consumers for participation in initial Connective Treatment Demonstration.	Design Operations Team	December 31, 2000
Implement one Connective Treatment Demonstration site (as described on pages 43 to 45)	Design Operations Team	February 1, 2001
Identify role of Consumer/Peer Supports within Assertive Treatment Teams	Design Operations Team	February 28, 2001
Complete hiring process for Assertive Treatment Team Coordinator, who will participate in program implementation	Design Operations Team	January 31, 2001
Select consumers for participation in Assertive Treatment Demonstration	Design Operations Team	March 31, 2001
Complete hiring process for Assertive Treatment Team staff	Design Operations Team	March 31, 2001
Begin 30-day Assertive Treatment Staff training program	Design Operations Team	April 1, 2001
Implement one Assertive Treatment Team (as described on pages 35 to 39)	Design Operations Team	April 30, 2001
Begin consumer and family member orientation to Assertive Treatment	ATT staff	April 30, 2001
Monitor and evaluate proficiency of each demonstration site for six months after start-up	Design Operations Team	November 1, 2001 to October 30, 2001
Expand Connective Treatment Sites throughout case management system	Design Operations Team	August 1, 2001 to December 1, 2001
Expand Supportive Treatment Sites throughout CM system	Design Operations Team	September 1, 2001 to January 1, 2002
As funding allows, expand Assertive Treatment teams	Design Operations	October 1, 2001 to April 1, 2002

V. CONCLUSION

In conclusion, the goal of this plan is to develop well functioning clinical teams to serve Seriously Mentally Ill consumers in Maricopa County. The method chosen to accomplish this goal is to infuse service design and intensity, job descriptions, training, including skill and competency training, policy and procedure, administrative oversight, and outcome evaluation with the necessary elements to deliver services according to the criteria.

APPENDIX A – Case Management and Clinical Services Cross Reference Chart
To Appendix B *Functional Criteria for Clinical Team Services*

Attach-ment B Criteria	Criteria Essential	Necessary Not Essential	Apply to All Clients	Resource Depend.	Additional Resources Required	Job Resp	Policies & Proced	Perform-ance Measures	Indiv. Compet	Team Compet	Admin. Respon	Comments
Indicator: CRISIS CAPABILITIES WITHIN THE TEAM												
1a.	X		X			X	X		X			
1b.	X		X			X	X		X			
1c.		X		X	X	X	X		X			
1d.	X		X				CRISIS		X	X		
1e.	X		X				X		X			
1f.	X		X	X		X			X			
1g.				X							X	
Indicator: STRONG CLINICALLY ASTUTE LEADERSHIP												
2a.	X		X	X	X	X	X					
2b.		X		X	X	X						
Indicator: MULTIDISCIPLINARY APPROACH WITH SHARED RESPONSIBILITIES												
3a.	X		X			X	X			X		
3b.	X		X			X	X		X	X		
3c.	X		X			X	X		X			
3d.	X		X			X	X		X	X		
3e.		X										

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Attach-ment B Criteria	Criteria Essential	Necessary Not Essential	Apply to All Clients	Resource Depend.	Additional Resources Required	Job Resp	Policies & Proced	Perform-ance Measures	Indiv. Compet	Team Compet	Admin. Respon	Comments
Indicator: MULTIDISCIPLINARY APPROACH WITH SHARED RESPONSIBILITIES												
3f.		X		X		X	X		X			
Indicator: STAFFING INTENSITY AND LOCATION OF SERVICE												
4a.	X		X	X	X		X		X	X		
4b.	X		X				X		X	X		
4c.	X		X					X	X	X		Goal would be for the team to identify the need for additional services and either provide or arrange authorization of certain services is a RBHA responsibility
4d.		X										
4e.	Propose the following alternative language:					X						
4f.	Treatment plans will identify the frequency and type of contact needed taking into account consumer preference and clinical need. Teams will monitor contact frequency so that contacts are conducted as per treatment plan.					X						
Indicator: DEFINITION OF ROLES WITHIN THE TEAM/ORGANIZATION												
5a.	X		X					X			X	
5b.	X		X					X			X	
5c.	X		X					X			X	

APPENDIX A – Case Management and Clinical Services Cross Reference Chart
To Appendix B *Functional Criteria for Clinical Team Services*

Attach-ment B Criteria	Criteria Essential	Necessary Not Essential	Apply to All Clients	Resource Depend.	Additional Resources Required	Job Resp	Policies & Proced	Perform-ance Measures	Indiv. Compet	Team Compet	Admin. Respon	Comments
Indicator: OPEN/CLEAR COMMUNICATION AMONG MEMBERS												
6a.	X		X				X	X			X	
6b.	X		X	X			X			X		
6c.	X		X	X			X		X			
6d.1	X		X				X		X	X		
6e.1		X		X								**Meeting Matrix replaces this section**
6d.2												
6e.2	X		X						X	X		
6f.		**Resource Dependent X** **Additional Resources Required X**										**Replaced by Meeting Matrix**
6g				X	X							**Replaced by Meeting Matrix**
Indicator: PLANNING INCORPORATES ETHNIC/CULTURAL DIVERSITY												
7a.		X										
7b.	X		X	X	X		X					Consider combining 7b and 7c
7c.	X		X	X			X			X		
7d.	X		X									

APPENDIX A – Case Management and Clinical Services Cross Reference Chart

To Appendix B *Functional Criteria for Clinical Team Services*

Attach-ment B Criteria	Criteria Essential	Necessary Not Essential	Apply to All Clients	Resource Depend.	Additional Resources Required	Job Resp	Policies & Proced	Perform-ance Measures	Indiv. Compet	Team Compet	Admin. Respon	Comments
Indicator: STRONG LINKAGES WITH OTHER SERVICE AGENCIES												
8a.	X		X	X					X			
8b.								X				
8c.	X		X			X	X		X	X		
8d.	X		X	X		X	X		X			
8e.	X		X								X	
8f.	X		X				X				X	
Indicator: CLINICAL TRAINING AND TECHNICAL ASSISTANCE ARE PART OF WEEKLY SCHEDULE												
9a.	X		X	X		X	X		X			
9b.				X	X							
9c.				X	X				X	X		
9d.				X	X							
Indicator: EACH MEMBER OF TEAM HAS SKILLS/ TRAINING TO PROVIDE CLINICAL SERVICES												
10a.	X		X	X					X			
10b.	X		X	X							X	
10c.	X		X	X			X		X			
10d.	X			X							X	

APPENDIX A – Case Management and Clinical Services Cross Reference Chart

To Appendix B *Functional Criteria for Clinical Team Services*

Attach-ment B Criteria	Criteria Essential	Necessary Not Essential	Apply to All Clients	Resource Depend.	Additional Resources Required	Job Resp	Policies & Proced	Perform-ance Measures	Indiv. Compet	Team Compet	Admin. Respon	Comments
Indicator: PRESENCE OF CONSISTENT QM AND ACCOUNTABILITY												
11a.	X		X	X							X	
11b.	X			X							X	
11c.				X							X	
11d.		X		X							X	
Indicator: CARE IS EMPIRICALLY DETERMINED												
12a.	X		X								X	
12b.												
Indicator: CAPACITY OF THE TEAM TO PROVIDE PROVIDES SERVICES												
13a.	X		X			X			X			
13b.	X		X			X			X			
13c.	X		X						X	X		
13d.	X					X	X		X	X		
13e.	X					X	X		X	X		
13f.	X					X	X		X	X		
13g.	X					X	X		X	X		
13h.	X					X	X		X	X		
13i.	X		X			X	X		X	X		

APPENDIX A – Case Management and Clinical Services Cross Reference Chart

To Appendix B *Functional Criteria for Clinical Team Services*

Attach-ment B Criteria	Criteria Essential	Necessary Not Essential	Apply to All Clients	Resource Depend.	Additional Resources Required	Job Resp	Policies & Proced	Perform-ance Measures	Indiv. Compet	Team Compet	Admin. Respon	Comments
Indicator: CAPACITY OF THE TEAM TO PROVIDE PROVIDES SERVICES												
13j.												
13k.												
13l.	X		X			X	X		X	X		
Indicator: INTEGRATION OF PHYSICAL AND BEHAVIORAL HEALTH (INCLUDING SUBSTANCE ABUSE)												
14a.	X		X			X	X		X	X		
14b.	X		X			X	X		X	X		
14c.	X		X				X					
14d.	X		X			X	X		X	X		
14e.		X										
14f.	X		X			X	X		X	X		
14.g	X		X			X	X		X	X		
14.h	X		X			X	X		X	X		
14.i	X		X			X	X		X	X		
Indicator: AVAILABILITY OF A FULLY FUNCTIONAL MIS SYSTEM TO SUPPORT THE WORK OF THE TEAMS												
15a.		X	X	X	X						X	.
15b.	X		X	X	X						X	

APPENDIX A – Case Management and Clinical Services Cross Reference Chart

To Appendix B *Functional Criteria for Clinical Team Services*

Attach-ment B Criteria	Criteria Essential	Necessary Not Essential	Apply to All Clients	Resource Depend.	Additional Resources Required	Job Resp	Policies & Proced	Perform-ance Measures	Indiv. Compet	Team Compet	Admin. Respon	Comments
Indicator: DEMONSTRATED RESPONSIVENESS TO CONSUMERS' NEEDS-ALLIANCE AND ADVOCACY												
16a.	X		X			X	X		X	X		
16b.	X		X								X	
16c.		X										
Indicator: REASONABLE REQUIREMENTS FOR DOCUMENTATION												
17a.	X		X								X	
17b.	X										X	
17c.		X									X	This will require a reduction of current paperwork requirements. Recommend a workgroup be established to accomplish this task.

APPENDIX B - FUNCTIONAL CRITERIA FOR CLINICAL TEAM SERVICES

INDICATORS	FUNCTIONAL CRITERIA
1. Crisis capabilities within the team	a. All team members identify a crisis in consistent terms and define it consistently to the consumer, family and other caregivers. Protocols for preventing, intervening and stabilizing a crisis are defined and demonstrated consistently by team members. The protocols identify assessment criteria, precautions, response time, required intervention and stabilization actions according to assessment conclusions, safety precautions, follow-up and reporting requirements.[1] Individual, as well as collective team members' responsibilities (including back-up), are defined for these protocols. b. Protocols for responding to requests and assisting crisis programs and emergency personnel (including emergency rooms, crisis centers, teams, police, etc.) are used by the team. The protocols identify how the team provides information, back-up and direct assistance, and team member responsibilities (including back-up call responsibility). The protocols are demonstrated consistently by team members which include how the team provides information on a 24 hour, 7 day a week basis. c. ACT Teams have an on call system, consistent with RHBA requirements for team on call systems, in which a team member is available to respond to a request or emergency call 24 hours a day, seven days a week. d. Each team member either knows the consumer's crisis plan or has immediate access to that information, and demonstrates ability to use the plan to respond according to the plan. e. Each person served by the team whose recent psychiatric history includes a crisis, has a crisis plan that includes information about potential precipitating events and signs, what interventions have been effective, who to call and what interventions have not been effective. f. At a minimum, each team member has a basic demonstrated level of crisis prevention, intervention and stabilization skills.[2] g. Under the supervision of the PBHP, team members have authority for decision making for a consumer during a crisis to the extent legally permitted and clinically advisable.

[1]The times and specific actions for crisis response should be delineated in company procedure
[2]Required core competency

APPENDIX B - FUNCTIONAL CRITERIA FOR CLINICAL TEAM SERVICES

INDICATORS	FUNCTIONAL CRITERIA
2. Strong clinically astute leadership	a. Each team includes a PBHP who serves as the clinical supervisor for the team and who meets ADHS requirements as a PBHP. b. Each team has a team leader with a masters degree in social work, nursing, psychology or psychiatric rehabilitation and a minimum of demonstrated competence in serving the target population in a community setting (it is desirable but not mandatory that the team leader has experience working on a team and as a supervisor).
3. A multidisciplinary approach with shared responsibilities	a. Treatment plan development and monitoring, service planning, problem-solving, sharing knowledge of resources and back-up (back-up is defined as standing in for the person with primary case management responsibility when the primary case manager is not available) occurs through a multi-disciplinary team approach. b. Each team member provides back-up, participates in problem solving, provides treatment and service planning ideas and contributes information on available resources for each consumer served by the consumer's clinical team. Each member is responsible for providing input on service and treatment planning, problem solving and information on resources based on their professional expertise and experiences.[3] c. The nurse and psychiatrist are required to provide information to consumers and team members regarding drug interactions, possible side effects, and potential benefits for each drug prescribed. This includes a requirement for designated clinical staff to train all members of the team on how to report on changes, interactions, and significant events for each consumer served. d. All treatment planning decisions are made through a shared, multi-disciplinary treatment planning process. Service provision is provided individually based on the consumer's needs. e. Individually based on the consumer's needs, psychiatry and nursing are represented on a team; either psychology, social work, rehabilitation counseling disciplines with one person master's prepared are also assigned to each team. It is desirable that a peer specialist and bachelor's prepared mental health or substance abuse treatment worker with experience be assigned to each team. f. ACT Teams have an on call system, consistent with RHBA requirements for team on call systems, in which a team member is available to respond to a request or emergency call 24 hours a day, seven days a week. The RBHA crisis system is available for other non-ACT teams.

[3] This requires each member to stay current with resources, professional information and literature on best practice, research, new protocols, treatments and medications.

APPENDIX B - FUNCTIONAL CRITERIA FOR CLINICAL TEAM SERVICES

INDICATORS	FUNCTIONAL CRITERIA
4. Staffing intensity and location of service	a. The size of the clinical team and ratio of staff to consumers is based on an individualized functional level of care determination that is continuously determined; assignments are adjusted accordingly. b. The team adjusts service level for consumers rather than shifting clients from one team to another based on level of need unless a consumer's needs change dramatically and this change is sustained over an extended period of time. c. The team has the capacity to rapidly increase service intensity for a consumer as his or her status requires it. d. For consumers with the most intensive service needs, their progress is tracked by the team on a individually determined basis, up to daily, when clinically indicated. e. ACT Teams maintain a goal of providing 50% of contacts in the community.
5. Clear definitions of roles within the team/organization	a. Job descriptions clearly identify roles and responsibilities of members of the team written to reflect roles within the team. b. Protocols are present for each team that identify roles regarding treatment planning, service planning, how decisions are made, back-up provisions sharing of information for each professional. c. Clear lines of authority within the agency structure beyond the team are identified.
6. Open/clear communication among members	a. Critical issues are discussed with input provided by all team members and resolution is reached at the end of the discussion. b. Each team member is trained in communicating clinical information.[4]

[4]Core competency requirement

APPENDIX B - FUNCTIONAL CRITERIA FOR CLINICAL TEAM SERVICES

INDICATORS	FUNCTIONAL CRITERIA
7. Planning incorporates ethnic/cultural sensitivity	**Need to develop plan on how to demonstrate ethnic/cultural issues are taken into consideration and not ignored** a. Each treatment and service planning decision takes into consideration cultural and ethnic diversity of the individual being served. The treatment plan reflects cultural and ethnic issues that impact service planning and provision were addressed. b. Each team that serves more than 25% Spanish-speaking consumers includes a team member fluent in that language. c. For consumers who do not speak English at a level that allows them to meaningfully participate in the service planning process, interpreters should be provided. Interpreters may include utilizing family/friends when available and with the consumer's consent. d. When ethnic and cultural issues impact the assessment and treatment planning process, the ISP should reflect these issues and accommodations, e.g. family interventions and approaches used.
8. Strong linkages with other service agencies[5]	a. Each team member is assigned to and demonstrates competencies in accessing services for persons served by the team in the following areas: supported housing, residential services, substance abuse services, rehabilitation, career and vocational services, peer supports, long term and primary medical care, non mental health related community resources and other services as needed.[6] b. Protocols for service responsibility exist to assure there is coordination and clear understanding of responsibilities between service providers and other team members; the team retains clinical authority for a consumer. c. Teams are required to refer consumers to services identified on the treatment plan unless documentation supports the service being fully provided by the team. In instances where resource limitations prevent the member from accessing services to which they are referred by the team, documentation will reflect that the referral, resource limitations and appropriate alternatives were discussed with the member and appropriate action taken. Appropriate action may include placing the member on a waiting list or referral to alternative services. It may not be appropriate to refer a member to services which are known to be unavailable.

[5] According to well-defined practice, persons served by assertive community treatment teams will primarily receive their services from the team and the team is considered an alternative to service or in some case the "primary service"; vocational, substance abuse and housing specialists are added to the team

[6] Core competency requirement

APPENDIX B - FUNCTIONAL CRITERIA FOR CLINICAL TEAM SERVICES

INDICATORS	FUNCTIONAL CRITERIA
8. Strong linkages with other service agencies (continued)	d. Service/agency representatives attend, or have meaningful participation in, all scheduled treatment team meetings and conferences for all consumers who are attending their program(s) or assigned to their service on a regular basis, and participate as team members in all decisions, assessments and assignments as determined by the team. Meaningful participation can include written or verbal input into assessment and treatment planning issues prior to the team meeting. Meeting attendance is not required. e. Each agency provides the team with current information on how to access services; a liaison/ombudsman to work out difficulties in referrals and specific information on admission and discharge criteria and vice versa. f. Each agency is required to provide notice of pending discharges except in emergency situations[7] as required by contract and level of care requirements.
9. Clinical training and technical assistance are a part of the weekly schedule	a. Clinical supervision is provided based on agency policy and behavioral health licensure requirements. b. See Training Plan sections for required training.
10. Each member of the team has the skills/training to provide clinical services to consumers	a. Each team member demonstrates core competencies in the following: psychiatric assessment in accordance with their professional training; crisis prevention, intervention and stabilization; substance abuse assessment; assisting a person to engage in substance abuse treatment and to have successful follow-up to that treatment; assisting a person to gain access to and sustain rehabilitation (psychiatric and vocational), housing and employment; interventions to help consumers build self-esteem and to begin and sustain recovery; support for consumers in making decisions; skills to teach and assist a person maintain self-monitoring and symptom reduction techniques (including providing information on somatic treatment); assisting a person with personal growth, problem solving, basic orientation and direction (for persons with psychotic or disorienting symptoms); self care capability; assessing physical health status and monitoring; knowledge of medications/somatic treatment; and, treatment planning and follow-up.[8] b. Each member of the team is provided in-service training on a regular basis to assure their knowledge is current and that they have the opportunity to refine and improve their skills

[7]Emergency situations are defined in the provider agency contract with the RHBA
[8]Core competency requirement

APPENDIX B - FUNCTIONAL CRITERIA FOR CLINICAL TEAM SERVICES

INDICATORS	FUNCTIONAL CRITERIA
10. Each member of the team has the skills/training to provide clinical services to consumers (continued)	based on regularly scheduled evaluations. c. Each member is evaluated on their skills in the above areas on a regularly scheduled basis.[9] d. It is assumed the RBHA will assure specialized teams, e.g. dual diagnosis, ASH and homeless, have training sufficient to carry out these tasks.[10]
11. Presence of consistent quality management and accountability See the Quality Management Section of the Document for details on performance indicators	a. The RBHA identifies quality management indicators to be used by each agency (including the RBHA) providing clinical team services, under contract, to assess the quality of team services. b. Each agency identifies these and any additional indicators they choose, how they are to be measured, how staff, consumers, Board members and others receive feedback on both the measures and results in a plan document that must be approved annually by the RBHA. c. The indicators listed in this document are the core indicators for this purpose and include the following: consumer satisfaction/dissatisfaction with services as defined by an external consumer based review group, the number of complaints and grievances filed against an individual team member or a team, aggregated data on outcomes and performance. d. Accountability factors may include team ratings on timeliness and quality of documentation, compliance with agency and RBHA policies, ability of the team to make and receive referrals on a timely basis, and ability of team to respond to and resolve crises of team members (weighted for level of care needs for each team).
12. Care is empirically determined (such as use of outcome measures)	a. Admission and level of care criteria are in place that establish the amount, scope, duration and type of interventions a persons should receive based on the acuity and disabling problems that result from the person's mental illness. These criteria establish the type (based on level of care or special need) and level of service for which a person should receive services and expected outcomes for persons served at that defined level of need.

[9] Staff evaluations are conducted during their probationary period and at least annually thereafter
[10] Specialized competency requirements

APPENDIX B - FUNCTIONAL CRITERIA FOR CLINICAL TEAM SERVICES

INDICATORS	FUNCTIONAL CRITERIA
12. Care is empirically determined, such as use of outcome measures (continued)	b. These criteria are used for first assignment and for continued stay criteria. Each person's needs should be continuously assessed and services modified as needed, minimally at each service plan review, to determine the level of care recommended by the team[11] or asked for by the person being served. No person being served should be placed on a team providing services for persons needing a higher level of care without an empirical review of their need, consultation with and consent of the individual and a review of the potential risks and supports that a person may have that should influence assignment beyond the empirical review.
13. Capability of the team to provide services	a. Each consumer is provided basic case management including coordinating and monitoring activities of the treatment team by a team member assigned as the person's primary case manager; each professional on the team may be assigned primary case management responsibilities. b. Each consumer is provided symptom assessment and management and individual supportive services. c. The team's psychiatrist conducts psychiatric evaluations for each consumer on the team, prescribes medication when appropriate, treats side effects appropriately, regularly reviews a person's response to medication and educates the consumer regarding his or her treatment and the effects of medication. With education and guidance from the team psychiatrist, all team members assess and document symptoms, behavior and side effects and assist in consumer symptom and side effect education. d. The team arranges for each consumer to obtain assessments of job-related interests and abilities, rehabilitation services needs and/or educational interests. The team provides or arranges for consumers to find and maintain employment (including on the job support as necessary), rehabilitation services or education when the assessment identifies goals or interests in one or more of these areas. In lieu of those services, each consumer's rehabilitation or education plan becomes part of their overall treatment plan, as needed, based on assessment information and the person's goals. e. The team arranges for and/or provides support activities of daily living for each consumer in community-based settings. These activities range from engagement, problem solving, side-by-side assistance, environmental adaptations, supervision and skills training, as needed, based on assessment information and the person's goals.

[11] Certain events such as a person being incarcerated or hospitalized could automatically trigger a review

APPENDIX B - FUNCTIONAL CRITERIA FOR CLINICAL TEAM SERVICES

INDICATORS	FUNCTIONAL CRITERIA
13. Capability of the team to provide services (continued)	f. The team arranges for and/or provides social, interpersonal and leisure-time skills training, planning, problem-solving and support for each consumer in community settings or documents clearly that the consumer does not have any needs or requests for this type of support, as needed, based on the assessment information and the person's goals. g. The team provides/arranges for assistance for Independent Living Skills training and assistance for consumers to maintain their home, when their behavioral health issues impact their ability to maintain their home independently including assistance in obtaining basic necessities of daily life that include, but are not limited to, the following: financial support, transportation, legal advocacy and representation, and safe, affordable housing of their choice. The team facilitates referrals for available independent living skills services when their ability to maintain their home independently is impaired by non-behavioral health issues. h. The team provides/arranges for personal assistance for consumers to maintain their home when the consumer's psychiatric disability interferes with their ability to perform activities of daily living. i. The team provides education, support and consultation to consumers' families and other major supporters with the consumers' consent. This includes education about mental illness and the role of the family in the therapeutic process, intervention to resolve conflict and ongoing collaboration based on assessment information and the person's goals. j. The team members are familiar with available supports in each of the categories above so that the supports and services can be utilized to their fullest extent possible. k. The team designates a member to become proficient in and provide the specialized services and interventions above, to assure that the team has the proficiencies needed to carry out these functions. l. Assessments and planning in each of the areas listed above is included in the consumer's treatment plan when applicable.

APPENDIX B - FUNCTIONAL CRITERIA FOR CLINICAL TEAM SERVICES

INDICATORS	FUNCTIONAL CRITERIA
14. Integration of physical and behavioral health (including substance abuse treatment)	a. There is documentation of physical health service needs. There is clear indication in the record (in treatment plan and supported in progress notes and treatment team meeting minutes) of how the physical and behavioral health care are being integrated. Joint conferences and discussions will occur on the provisions of treatment , timely and easy flow of documentation, protocols for assistance by the team in accessing physical health services or providers. Documentation of this information will be consistent with documentation of physical health problems noted in the clinical record and through interviews of consumer. b. Referral for physical health services is conducted in a manner to assure that consumers understand and can respond to requirements for accessing the needed service. If the consumer cannot respond independently, there is evidence of arrangements for assistance to the consumer to access services and documentation of follow-up by the team to assure service is rendered and that a report is received by the team. If additional follow-up is needed, there is evidence that it was also arranged as described above. c. The team will have documentation of the person's health care coverage, PCP name, address and phone number. d. There is documentation that the team makes the treating facility or practitioner aware of the consumer's needs psychiatric status and history, to the extent necessary for the facility or practitioner to treat the person successfully, is evident. e. The team helps the person prevent health problems through education provided in a manner and at a level the person receiving the service can understand.

APPENDIX B - FUNCTIONAL CRITERIA FOR CLINICAL TEAM SERVICES

INDICATORS	FUNCTIONAL CRITERIA
14. Integration of physical and behavioral health (including substance abuse treatment) (continued)	f. The team has current information about how to access substance abuse services for persons they serve. g. Team members make accurate assessments of the person's needs in such a manner to accurately determine what type and level of substance abuse service should be pursued; there is consistency between the documented needs and team interventions and referrals. h. Integrated services are provided when working with individuals with co-occurring disorders as evidenced by joint planning and joint interventions by all involved service agencies/providers. i. The team is involved in the engagement, persuasion and follow-up phases of substance abuse treatment.
15. Availability of a fully functional MIS system to support the work of the teams	a. The MIS system has functioning components for recording, easily updating, and revising all treatment plan meetings, treatment plans, service referrals, assessments, all other required documentation, events including crisis encounters, prescribed medication, changes in medications, potential medical complications, possible negative responses to drugs, medication and medical history, summaries of progress in all services, progress notes and updated and timely level of care documentation, authorizations, appeals, etc. b. Reports are submitted to teams on progress, outcomes, deficiencies and trends and other issues as requested by the teams.
16. Demonstrated responsiveness to consumers' needs – alliance and advocacy	a. The team makes all consumers aware of peer supports, advocacy organizations and other groups and where necessary makes arrangements for contacts to these organizations. This information and actions taken to arrange contacts is documented in each person's record. b. The team regularly receives feedback from persons about the services and supports they provide, how responsive the services are to their needs and how responsiveness the team is in their personal recovery and demonstrates actions and improvements based on this feedback. c. The team members support persons they serve to form alliances for action, either as an individual group or part of a larger group, as evidenced in team meeting minutes and records.

APPENDIX B - FUNCTIONAL CRITERIA FOR CLINICAL TEAM SERVICES

INDICATORS	FUNCTIONAL CRITERIA
17. Reasonable requirements for documentation	a. The record format and document requirements will be streamlined where possible with users providing feedback on chart format. b. There will be continuous review to assure requests and requirements are not redundant and unnecessary. c. Documentation requirements will not require any team member to be spending in excess of 30% of their available work time to complete within the required timeframes.